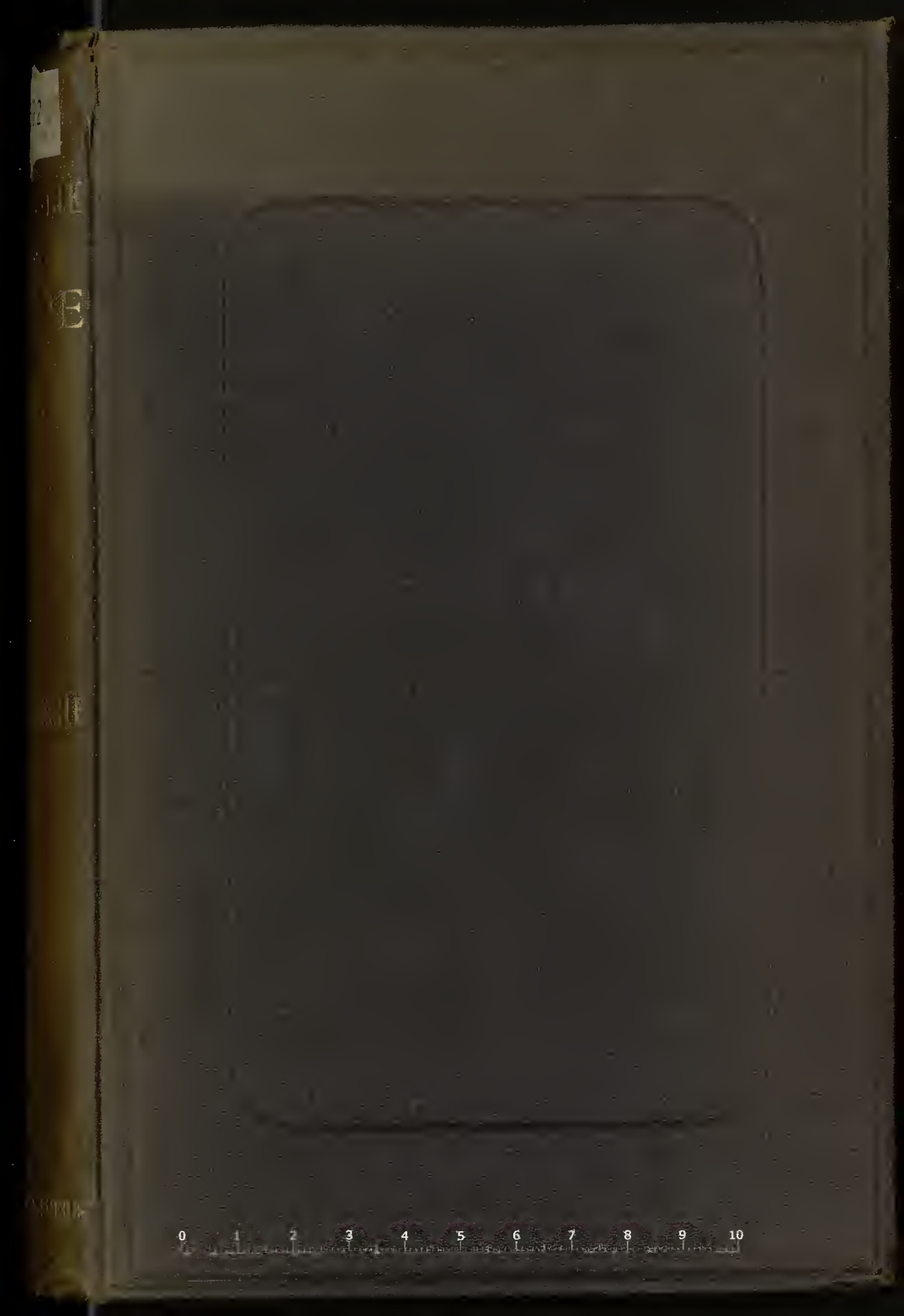


THE CARE AND CURE OF THE INSANE.

VOLUME II.

THE CARE AND CURE OF THE INSANE:

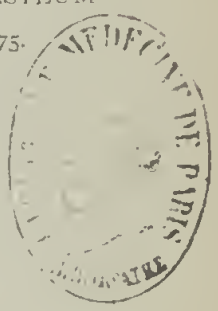
BEING THE

REPORTS OF *THE LANCET* COMMISSION ON LUNATIC ASYLUMS, 1875-6-7,

For Middlesex, the City of London, and Surrey,

(REPUBLISHED BY PERMISSION)

WITH A DIGEST OF THE PRINCIPAL RECORDS EXTANT,
AND A STATISTICAL REVIEW OF THE WORK OF EACH ASYLUM
FROM THE DATE OF ITS OPENING TO THE END OF 1875.



BY

J. MORTIMER GRANVILLE, M.D., F.S.S.,

ETC.

IN TWO VOLUMES.

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RETROSPECT.

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The Asylum Question.

The following Reports relate to the "Metropolitan Licensed Houses" receiving pauper patients, visited by *The Lancet* Commission, viz. :—

CAMBERWELL HOUSE.

J. H. Paul, M.D., M.R.C.P., F.R.C.P. Edin., F.R.C.S., etc.; and F. Schofield, M.D., M.R.C.S., etc.

BETHNAL HOUSE.

John Millar, L.R.C.P., L.C.S. Edin., etc.

HOXTON HOUSE.

J. Cremonini, Esq., M.R.C.S., etc.

PECKHAM HOUSE.

A. H. Stocker, M.D., M.R.C.P., M.R.C.S., etc.; and J. A. Brown, Esq., M.R.C.S., etc.

GROVE HALL, BOW.

E. H. Byas, Esq., M.R.C.S., etc.; and W. J. Mickle, M.D., M.R.C.S., etc.

THE

CARE AND CURE OF THE INSANE.

THE "METROPOLITAN LICENSED HOUSES" RECEIVING PAUPERS must be regarded as occupying a position, and lying under obligations to the public, intermediate between those of county and borough asylums and exclusively private establishments. The asylums are in the broadest sense public, maintained by public funds, and administered on behalf of the public by a committee of justices, and officers duly appointed, and paid out of the public rates, to discharge a public duty. The private establishments, although very properly placed under the supervision of the Commissioners in the interests of humanity and social prudence, are personal ventures, and it is a matter of contract between the proprietor and the friends or guardians of a lunatic how he shall be treated. The law only applies to the bargain so far as it casts the protection of the State around all its members, adapting the obligations it imposes to their special needs.

The licensed houses receiving paupers are, therefore, private establishments undertaking work by contract for the State. They are amenable to the regulations prescribed by law for all asylums, and they are open to inspection and subject to remark as quasi-public institutions, for the time being at least, performing a public service. It is necessary this should be understood; because the five "Metropolitan Licensed Houses" upon which the Commission has yet to report—in

order to complete the survey of pauper lunatic asylums in and near London—must be treated with the same freedom in respect to their efficiency that has been used in dealing with the "County and Borough asylums," the "Workhouse" asylums, and the "Hospitals" upon which we have already reported.

METROPOLITAN LICENSED HOUSES.

(*Five receive Paupers.*)

I.—*CAMBERWELL HOUSE.*

This establishment is a series of buildings pleasantly situated on opposite sides of the Camberwell New Road. There are three blocks on the north and two on the south. The property throughout has been adapted, and consists of a tenement of considerable size, once used as the Naval School, and four private residences. Additions have from time to time been made as became necessary. The grounds are extensive, covering nearly twenty acres, and laid out with excellent effect. From some points of view it is difficult for the visitor to believe himself so near London. The general aspect of the establishment is cheerful; and it does not present any feature characteristic of a place of detention for lunatics. The house was opened for 220 patients in 1846, with the view of meeting the then pressing demand for additional accommodation for insane paupers. Before the close of the first year the number of inmates was raised to 333. The reception of patients belonging to the middle classes of society grew out of the enterprise.

At the present moment Camberwell House is licensed for 483 inmates, and of the 406 resident on the 1st of January in this year, 1876, 270 were private patients and 136 paupers. It is with these last we are especially interested, but of the asylum as a whole there will be something to say. The charge made by the "licensed houses" for paupers is, generally, 19s. 3d. per week. It is therefore reasonable to expect they should be well cared for. As far as we can judge, after careful inspection, the condition of pauper lunatics at Cam-

berwell is fairly satisfactory. They are not kept altogether aloof from the other inmates, but distributed as their condition seems to render expedient. Throughout the establishment patients are apparently grouped rather on the basis of their previous history, their mental state, and their habits, than their present financial position. Some of the superior class of inmates are accommodated in houses on the south of Camberwell Road, but even to these more luxurious residences, we were informed, paupers are not unfrequently transferred when their social state and habits render the change desirable. It is only natural to expect that the pauper inmates of a mixed establishment will be less carefully provided with comfortable and pleasing surroundings than patients of higher grade. This expectation is to some extent, of course, realized at Camberwell House; but searching jealously for the proofs of a difference in treatment, we find considerably less evidence than might have been anticipated. Indeed, there is practically very little distinction between the lower-class private patients and the paupers.

The house has been, as we remarked, adapted, instead of being built, for an asylum. In some respects this is not disadvantageous, because, the residential property being originally of a superior class, and the cubic air-space ample, there is a diversity in the construction of day-rooms and dormitories seldom found in a building planned and erected purposely as an asylum, but which imparts an air of homeliness eminently desirable. Having said thus much in favour of the house, it is incumbent to observe that the property throughout stands in need of repair. The system of painting, papering, and generally renovating large establishments piecemeal does not always work well. The same remark applies to the matter of refurnishing. Notwithstanding the very large outlay it would necessitate, we think Camberwell House, with the exception of the portion appropriated for first-class inmates, ought to be "restored."

We notice that the Commissioners have from time to time complained of the bedsteads and bedding. Much has recently been done to improve the state of matters in this particular. New bedsteads have been provided, and gradually, perhaps too tardily, the old-fashioned and worn-out furniture

is being replaced by new. Many of the beds are supplied with hair mattresses, and it is pleasant to notice that while in this and other improvements there is progress without stint, what is accomplished benefits patients of all classes—the well-to-do and the poor impartially. It would, however, seem desirable that the business should be pushed forward with greater energy, and it ought to be supplemented by the provision of new fittings, better provisions and appliances for bathing and washing, with attention to details—for example, the placing of small filters for drinking water in the dormitories, which, with a few exceptions, are at present unsupplied. These points may seem almost too trivial to notice, but life is made up of trifles, and such petty affairs as the supply of towels, brushes and combs, clean tablecloths, properly appointed dinner services, and the like, compose the domestic system, and play no inconsiderable part in shaping and maintaining the curative *régime* of an asylum for the insane.

Taking our impression entirely from what we have observed, we suspect a certain lack of discipline is the weak point in the management at Camberwell House. The arrangements are, generally speaking, good, although the house and its belongings must, to some extent at least, be described as susceptible of improvement. It is in the carrying out of the system there is possibly something to be desired. The method of dealing with the insane in force at this asylum strikes us as exceptionally humane in principle. The windows are nowhere barred—on the ground floor they open freely; on the higher levels they are securely blocked, with a safe space for ventilation. The doors are not kept locked, and the patients wander in and out of the house, using the pleasant grounds freely. Access to the bedrooms is allowed, and going unreservedly among the patients, we were strongly impressed with their apparent comfort and contentment. The system of liberty for walks on parole is largely adopted, and so far with satisfactory results. Probably in few asylums do the inmates wear a less dejected appearance; at scarcely any house have we encountered fewer complaints of detention. This is significant, for the patients are evidently under no terrorism, and were unreservedly at liberty to state their grievances. The practical question is whether the same air

of cheerfulness and evident sense of freedom might not be combined with a higher development of control.

To speak frankly, and it is no use visiting an asylum unless we can do this with impunity, it is impossible to avoid feeling that Camberwell House is a place where accidents—which are really accidents, and for which no superior officer can be held to blame—are likely to occur. There is too much easy-going, good-natured leniency on the part of some of the attendants, and a suspicion of peevishness —the irritability that springs from lack of interest—on the part of others. The term "discipline" can only properly apply to attendants. A discipline of insane people is absurd in conception, and it must be either tyrannous or grotesque in application; but the officials of an asylum require to be ruled with iron hand, withal it is cased in the velvet glove. Dr. Paul and Dr. Schofield are perfectly candid; they profess little; but it is easy to see they take a keen interest in the welfare of those committed to their care. They do not, however, seem to be thoroughly well supported. There is a lack of vigour and acuteness evident in the service of the attendants.

The Commissioners, in their report for 1875, just printed, express an opinion that the number of attendants is too small. The proportion is stated as about one to twelve inmates. Considering that there are many extra servants who sleep in the rooms with the patients, and help to supervise them by day, this proportion is not exceptionally defective.* It is in character quite as much as number, we suspect, the fault lies. They may understand their business, but many little matters we noticed betoken scant personal industry and vigilance.† In an asylum where so much depends upon the efficiency of attendants—and we believe rightly—as at Camberwell House, these officials need to be of a superior order. We do not mean to imply that they should be taken from a higher grade. Lady matrons and "lady-like" attendants are

* I have elsewhere insisted that the proportion must be much higher if the non-restraint system is to be carried out in its integrity and the main object be to cure by moral influences.

† Since this report appeared in *The Lancet* the attendants have been changed and the system of management generally revised by the proprietor. When remonstrances are received in this spirit, the circumstance calls for recognition.

seldom any good, while effusively genial and "gentlemanly" male officers are a delusion and a snare. The sort of attendant needed at Camberwell House is a business-like, firm and yet kind, type of officer, to whom order is a pleasure, industry a delight. There *are* such persons, although their name is not legion.

The private patients, of course, wear their own clothing; the paupers seem comfortably and decently provided. Some of the worst cases—and there are many troublesome, perhaps too many for the welfare of the establishment—appear more dishevelled than their mental plight would explain. Here, again, the attendants are principally at fault. The duty is done roughly, without sufficient painstaking. We did not see the patients generally at their meals; but the little observed in the shape of feeding failed to convey the impression that due care is bestowed on the way food is served. The quantity was apparently sufficient, and the system of allowing patients to be helped from the joint is good, if well carried out; but we think great trouble should be taken to make the assembling at table in any asylum an important and orderly proceeding. It is, morever, desirable, as we have hinted, that every meal should be served with some delicacy. If anywhere dining should be an institution, it ought to be in an asylum for the insane.

To return to our conjecture that accidents are not unlikely to occur—for to that these general remarks chiefly point—candour compels us to express a strong persuasion that the diligence, watchfulness, and judgment exercised by officials at this establishment are not adequate to the amount of liberty accorded. We did not detect that pervading air of order which is the secret of safety, and ought to be discoverable, in every part of an asylum so administered, down to the smallest detail; and we think such order is compatible with the highest sense of liberty and enjoyment of which the insane are capable. The principle of the system adopted is excellent; its working out, in which the subordinate officers are chiefly concerned, is imperfect: we question whether it is safe.*

* In reference to these and subsequent remarks, see the footnote on preceding page. An establishment reconstituted with a keen perception of its defects and

An opinion that the true treatment of insanity consists almost entirely in the daily management of the insane has been so repeatedly expressed in these reports, that it will not be necessary to discuss the topic afresh in connection with Camberwell House. So far as the success of a practice may be inferred from the apparent state of the patients treated, the medical care bestowed on the inmates of this asylum is wise and effective. We are not inclined to attach undue importance to the recent sad occurrence of a case in which the discovery of fractured ribs and sternum was made after the decease of the patient. Those who have had much to do with the insane know how strangely pain is disregarded and injuries are masked by lunatics. Nevertheless, expert and watchful attendants should be able to detect enough evidence of injury or disease to direct the scrutiny of a medical officer to a patient in bad condition. It must always be exceedingly improbable that a physician, walking daily through the wards of an institution like this, and speaking casually to his patients, should discover an injury of obscure nature, particularly in an excitable man. His attention would need to be specially called to the case; but an attendant ought to be aware of the condition of each patient under his or her care; hence the vital importance of securing the services of officials able and industrious enough to observe.

II.—*BETHNAL HOUSE.*

This is the third in point of size of the "metropolitan licensed houses" receiving paupers, but it is at present tenanted by a larger number of patients supported out of the public rates than will be found located in either of the other establishments on a similar footing. At Camberwell House there were 136 paupers in a total population of 406. At Bethnal House the return for January 1st, 1876, shows 250 paupers in a total of 380.

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earnest desire to amend them, will probably be more thoroughly efficient and trustworthy in the future than if no untoward experience had been gained. Dr. Paul and Dr. Schofield have been acutely anxious and earnest in their endeavours to reform what needed improvement.

Some historic interest attaches to this institution. To the gross neglect and inhumanity with which the insane were treated within its walls just fifty years ago we owe the reforms which have placed the treatment of lunatics generally on a more satisfactory basis, and invoked for their protection the vigilant guardianship of the law. In 1827 Mr. Gordon described the condition of matters at the "White House" in language* which stirred the sympathies of the Commons and the country, and, supported by the energetic philanthropy of the present Earl of Shaftesbury, then Lord Ashley, led to the passing of the measure of 1828, "to consolidate and amend the several Acts respecting county lunatic asylums, to facilitate the erection of county lunatic asylums, and to improve the treatment of pauper and criminal lunatics."

It is a striking proof of the good service accomplished by the Commission appointed subsequent to this exposure and in pursuance of the reforms instituted by Parliament, that the state of matters is so widely different to-day. The general treatment received by patients in Bethnal House is not less changed than the condition of its inmates. In place of neglect there is care, cruel indifference has ceased, and solicitude for the comfort and welfare of private and pauper patients alike, shapes the policy and controls the management.

Bethnal House comprises "the White House" and numerous additions. The structure is exceedingly irregular, and covers a considerable area, with recreation courts interspersed between the blocks. For an establishment so constructed, it is commodious, and presents few features which challenge criticism. Some of the rooms are low, but speaking generally the air space is ample, and the superficial extent sufficient. The paupers are kept apart from the private patients, but in other respects there is little apparent difference in the treatment of the two classes. The paupers sleep on flock beds, while those who are paid for by their friends enjoy the luxury of feathers; and for the former there is a "pudding" day, once a week, probably rather to the advantage of the patients than against their interest, although it might be better if the pudding were replaced by fish.

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* See vol. i., pages 84, 85.

The attendance seems efficient, and the dormitories are so arranged that in every apartment containing several beds an officer sleeps. The practice of placing a single patient in a room with one attendant is, as we have elsewhere urged, perilous. When two, three, or more patients are associated, the presence of a nurse in the dormitory may obviate the need of frequent disturbance by the night-watch, but we think *every* room should be visited at suitable intervals. It is the locking and unlocking of doors which proves a fruitful source of annoyance, not the quiet patrol of a judicious inspector. The proportion of attendants to patients is about one to twelve, all told.

The furniture is fairly good. A more liberal supply of brushes and combs in the sleeping-rooms would be desirable ; and such little matters as the provision of drinking water in each dormitory, prompt and better service at the dinner-tables, with an endeavour to make the function of feeding more orderly and decorous, might be urged upon the attention of the management; but a close review leaves very favourable impressions, and certainly discovers no occasion for complaint. In respect to one particular, of pre-eminent significance, it is pleasant to be able to speak warmly. Although the house is old, in some parts of great age, and the inmates are generally of a class requiring especial attention, we did not perceive a close atmosphere, or an offensive vapour throughout the establishment. Indeed, the cleanliness is remarkable, and reflects credit on the administration and the service.

Nothing speaks more strongly for the general conduct of an institution for the insane than this characteristic. There was no trace of that mysterious odour which pervades asylums even in open districts, and is too often set down to a peculiar emanation from the bodies of lunatics. As a matter of fact, we believe this "smell" is a convenient myth* that covers a multitude of sins in the matter of insufficient washing—with soap—and attention to the persons and clothing of the

* I do not mean to deny the existence of a characteristic odour associated with the insane, and possibly due to special secretions or the insensible perspiration; but the persuasion that a "smell" may generally be detected suggests an excuse for uncleanliness.

inmates. In many asylums the linen is imperfectly washed, and dried at a high temperature, which burns the foul vapours given off, and even the "clean" clothing is perceptibly contaminated. We have bestowed some attention on the matter throughout this inquiry, and it is abundantly evident that where attendants are vigilant and the laundry arrangements well cared for, *the foul linen being kept carefully apart*, the traditional hypothesis is not supported.

Regarding the establishment throughout, its efficiency as a lower middle-class asylum admits of no question. The health of the inmates is good. They enjoy a large amount of liberty, and are not irritated by needless or irksome discipline. The system of walks and rides beyond the grounds, with attendants and on parole, is in full use, and so far as we could judge from the answers supplied to questions asked, and by observation, it is judiciously applied. The only point in respect of which we were impressed unpleasantly was an apparent lack of occupation, either work or play. Too many of the patients sat, or stood, about without any great effort being made to engage their attention. The physician of Bethnal House is so experienced and practical a "psychologist"*—we use the term unwillingly and for want of a better—that he has doubtless noticed the habit to which we allude, and may fairly be urged to mend it. He has done good service in pointing out how some of the worst forms of insanity spring from a vice which is the offspring of idleness. It is, of course, exceedingly difficult to deal with the insane: there is no power to make them work—though the lack of such a power is, perhaps, a greater evil than its abuse would be. Nevertheless, listless brooding is one of the most mischievous of propensities, and it would be highly beneficial if some impulse to activity could be stirred in this institution. The system of rewarding patients for their labour is in force, and, we believe, every incentive to useful employment is adopted; but if the inmates will not work then, they should be pressed to play. We do not wish to imply that there is

* Dr. Millar is the author of a valuable little work entitled "Hints on Insanity" (Renshaw). I believe it is now out of print, but it comprises so many sound practical suggestions, and so much information, in a small compass, that I venture to hope it may be republished.

more inaction here than elsewhere, but, amid so much that is excellent, what appears to be a defect stands out with exceptional prominence, and, speaking freely, as we feel bound to speak, it may not be vain to urge that the only matter seeming to call for adverse remark, is one that deserves and would reward attention.

Restraint is used for surgical purposes, and occasionally at night, for the protection of the suicidal. We think the latter recourse is to be regretted. There is, however, only one way of obviating the use of mechanical appliances, and that necessitates a considerable outlay, less easy to meet in a private asylum, unless the patients pay well, than in a public institution—viz., an increase in the number of attendants. We have elsewhere strongly insisted that in all county and borough asylums, and institutions claiming the rank of hospitals, the question of cost ought to be put wholly on one side, and absolute requirement fulfilled at any expenditure. It is difficult to apply the same argument to the case of a private house, where patients are received at rates barely above those of an ordinary boarding-house.

For routine purposes the attendance at Bethnal House is apparently adequate. That it is *not* sufficient to prevent the occasional use of restraints is equally obvious. The discipline is so good, and the management so effective, that no difficulty is likely to occur except in regard to special cases; but in dealing with these, the resource should certainly be an increase in the staff of attendants rather than the use of measures shown to be ineffectual, and on many grounds open to objection as provocative of mental mischief. The general principles of the curative system adopted are intelligent, and the use of approved remedies and methods of grappling with the various forms of disease is energetic and advanced. A patient at this house is not only well cared for, but an honest and able effort is made for his recovery. From the medical standpoint not less than the humane, the treatment is sound, and, gauged by results, it is at least as successful as that pursued elsewhere.

III.—*HOXTON HOUSE.*

The name of this establishment recalls the inquiry of 1815, when, before a committee of the House of Commons, Dr. John Weir, inspector of naval hospitals; Dr. James Veitch, staff-surgeon in the navy; Dr. John Harness, a commissioner for sick and wounded seamen from 1800 to 1806, and afterwards a commissioner of the Transport Board; Mr. J. B. Sharpe, surgeon and apothecary, and Sir Jonathan Miles, proprietor of Hoxton House, disclosed or admitted a condition of matters in regard to the treatment of "naval maniacs at Hoxton" as deplorable as anything brought to light by the efforts of the legislature elsewhere.

The name "Miles" is still emblazoned on the door-plate, and it requires little effort of the imagination to conjure up the scene painted, of sixty-eight years ago, when—according to the admission of Sir Jonathan Miles, who, of course, cast the blame on somebody else—"in the year 1808 the patients were very badly clothed, and walked about the yard stark naked, with only a bit of blanket on them;" when most of the inmates, quiet or "enraged," slept on straw, and the clean and dirty cases together, in some instances two in a crib; and when, in reply to the question, "It is your opinion, then, that there are above 300 persons in your house who receive no attention whatever on account of the peculiar complaint for which they are confined?" Sir Jonathan naïvely replied, "Certainly, they have nothing prescribed for their cure, no doubt of that; their pay will not allow it!"

It must not be supposed that Sir Jonathan Miles was exceptionally careless of the mad folk committed to his charge. On the contrary, "the accommodations" of this establishment were described in a report put in evidence by Dr. John Harness, bearing the signature of Dr. Blair, and dated 1798, in flattering terms, and as in certain respects having "greatly the advantage of Bethlehem Hospital," so that the good doctor failed to "see in what further respect the situation of persons in their unfortunate circumstances could be materially improved." Our notion of the treatment humanity and prudence suggest for the care and cure of the insane has greatly

changed since the century began, and during the last thirty years, under the growing experience of a permanent Commission, it has advanced in a manner which must doubtless have severely taxed the enterprise of proprietors, probably extinguishing the possibility of making money out of any establishment not almost exclusively devoted to patients for whose custody and treatment friends are prepared to pay liberally.

Several practical considerations grow out of this last-mentioned circumstance, which it is necessary to bear in mind. Houses built and provided many years ago, before the new era commenced, cannot be compared with the standard of excellence, in respect to construction and arrangements, by which modern institutions are tried. We have already pointed out that this is not an unqualified evil. There is a certain character of homeliness about the older houses which has its advantages, remembering whence the patients in these establishments come and the class of houses to which they may return. The change from a residence of the class commonly occupied by the families of artisans and small shopkeepers to a palatial asylum must be startling, and may be good, but a sudden return to the old life and circumstances, in the case of those who are fortunate enough to be discharged "cured" or "improved," can scarcely fail to prove depressing, and in some instances disastrous. However that may be, the old houses do not, and cannot, come up to the modern conception of what an asylum ought to be. Nothing short of razing a building, or series of buildings, like the establishment at Hoxton, to the ground, and entire reconstruction, could make the house presentable. Classification at an institution of the kind is probably impossible, and it is scarcely attempted. No "improvements" could render an asylum, located in a densely populated neighbourhood and blocked in on every side, an agreeable place of residence.

These inexorable conditions of the *status quo* must be remembered, and it is incumbent upon any person attempting to form an impartial judgment as to the fitness of an institution of this kind for the purpose it professes to fulfil, to remember the class of patients accommodated, the amount paid for their support, and the terms upon which they are received.

Nothing would be easier than to run through any one of the licensed houses, and point out defects which "ought" to be remedied. It could not, however, be fairly expected that recommendations based on a judgment thus formed would have much weight—if the fundamental conditions were overlooked, and the changes proprietors were asked to make involved an expenditure beyond the bounds of commercial prudence, and were therefore unreasonable to suggest.

Throughout this inquiry, both as regards the public and private institutions visited, we have been careful to keep practical considerations in view, and we have no hesitation in saying that the reforms from time to time advocated, whether in relation to constructional or managerial matters, have been carefully weighed before putting pen to paper, and are urged under a sense of responsibility. It is gratifying to know that many of our recommendations have already been adopted, and we look with confidence to others being considered, and sooner or later carried into effect, by the authorities to whom the counsel or remonstrance has been addressed.

Hoxton House stands in need of a larger outlay and more considerable alterations than any one of the institutions we have previously visited. It is only fair to state that the circumstances in which this establishment is placed must prove exceptionally embarrassing. The license is for 325 patients. Of the 279 resident on the 1st of January, 1876, 222 were paupers; and when the new asylum at Banstead is opened, probably nearly all of these will be suddenly withdrawn. The removal of pauper patients without adequate notice is a serious obstacle to improvement at the metropolitan licensed houses, and Hoxton will probably feel the deprivation of support more than others, because the private patients at this establishment are of a class from whom a large revenue cannot be expected.

This, also, should be borne in mind, because it would be in the last degree unreasonable to complain of matters which no proprietor in the position of the owner of Hoxton House can be expected to remedy without some guarantee of a return for his money. The situation of the licensed houses receiving paupers is one which calls for a closer scrutiny than we are at present prepared to make. Meanwhile, looking at

the institution under notice, it is impossible not to feel that there are points to which attention must be directed, and for which a remedy may be fairly asked.

We have said the place is old, and past radical improvement. There is, however, one particular in which the condition of matters may be mended. It is a straggling compound of tenements, arranged on no intelligible plan, and generally ill-adapted for the purpose to which it is applied ; but some change for the better might be effected by throwing down certain of the divisional walls, and replacing the older and disused blocks with inexpensive day-rooms and dormitories of modern construction. We cannot help thinking the number of patients for which the place is licensed must have been determined on the basis of a computation of superficial and cubic space which included the disused as well as the occupied portions of the old establishment. This is a matter which demands consideration.

We make every allowance for the commercial difficulty already explained ; but that does not either account for or condone the error of crowding an institution with more patients than it can adequately accommodate. The day space, particularly in those portions of the house allotted to females, is manifestly insufficient. The circumstance that the patients generally appear contented reflects great credit on the management. Indeed, it is difficult to understand how superintendent and officials contrive to preserve not only tolerable peace but good temper, among women thrown together in the closest proximity, as are the inmates of these wards. We have seen institutions less crowded presenting indescribable scenes of turmoil and contention. The sleeping apartments are equally packed. The beds in some dormitories are placed much too near together. A series of single rooms, chiefly lighted and ventilated from the adjacent apartments, ought at once to be condemned : their atmosphere is inadequate, and the arrangement is altogether objectionable. These are evils calling for speedy reform.

Whether it might be practicable, by a fresh distribution of the inmates, to make this house a fitting place of residence for the number specified in the license is a point upon which we offer no opinion. Probably by pulling down the old

buildings still encumbering the ground—relics of a past that might with advantage be forgotten—space could be gained for the erection of a cheap and efficient block capable of accommodating some forty patients. It only remains to urge that a bold view of the situation should be taken, and, looking to the part the institution must ever play in meeting the need of the locality, a spirited effort should be made to render the supply commensurate with the demand. Whatever the vicissitudes through which the metropolitan houses may pass, the permanence of the reason for their existence is, unhappily for the population, beyond question. The airing courts at Hoxton are bare, and stand sorely in need of embellishment. The closet arrangements are far from satisfactory. The system of flushing by pails of water thrown down prevails,* and is obviously obsolete.

We have said the patients appear contented. There are the usual complaints of confinement, but these, as elsewhere, come from inmates no judicious superintendent would venture to discharge. Speaking generally, there is a satisfactory absence of significant tokens of neglect. We saw no black eyes or scratched faces, and although many excitable patients were present in the crowded day-rooms, order prevailed without any appearance of terrorism. The attendance is certainly good, and the establishment throughout seems well looked after. Unfortunately, the defect we were compelled to point out at Bethnal House is even more obvious here. The patients are unoccupied. This is a very serious evil. Remembering how important a part employment plays in the treatment of insanity, a purposeless existence comes to be an evil to which no lunatic should be exposed. The class of patients received at these houses will not work. They bitterly resent even the mildest remonstrance, and protest loudly against anything, however distantly, approaching pressure. A remedy must clearly be found for this state of matters. It is deplorable that there should be asylums in which patients are allowed to lounge through life "without utility or object." It is not alone that time is wasted: the chances of recovery are lessened, because one of the most potent, if not an indispens-

* I am informed that new closets are flushed with water laid on. There now only remain two sets of conveniences treated as described in the report.

able, means of cure is omitted. It would be unfair to hold medical superintendents wholly responsible for this omission. They have not the power to enforce work, a power they ought to possess as unreservedly as that of depriving a patient of liberty, or applying restraints.

Work is a moral remedy, and an integral part of the moral system of treatment. It is illogical and absurd in the last degree to withhold the right to employ a remedy not nearly so likely to be abused as the power which every medical superintendent possesses of placing his patients in seclusion and darkness, under the stupefying influence of drugs designed to produce quietness, or in any form of mechanical restraint. Meanwhile there can be no doubt but that a strange lack of ingenuity is evinced in the failure to find modes of occupation by which patients may be induced to exert themselves. We must be excused for expressing our opinion that the institutions in and around London are notably less well served in this particular than many in the provinces, whereas they ought to take the lead.

The appliances for amusement might, with advantage, be multiplied at Hoxton House, and there should be a better supply of illustrated periodicals. A good deal has been recently done to improve the state of things in this direction, but more is needed. The dietary seems to be sufficient; the patients are apparently well nourished. There is, however, the same want of attention to the serving which we have noticed elsewhere. A meal may be abundant in quantity and of good quality, but unless it is well placed on the table not even lunatics can derive the full benefit it is calculated to impart. It is therefore, we contend, not economical to be careless of the way a dinner is cooked or served.

Some of the domestic arrangements and appliances are old-fashioned. For example, the forks are webbed to within a few lines of the point, and the knives are carefully blunted until they must be useless for any purpose except that of tearing the meat. Why are precautions of this antiquated character necessary in some asylums and not in others? Why is it deemed unsafe to light a room with decent windows, available for looking through—without climbing on the top rail of a bedstead—at one establishment, while in other

houses the poor patient is permitted to enjoy the luxury of a prospect? We must confess our inability to account for these contradictory methods of dealing with the insane, and we can discover no excuse for the less considerate and comforting policy. We do not think any need exists in this asylum for the recourse to measures by which the circumstance of their being unworthy of confidence is perpetually thrust upon the inmates.

The attendants number in the proportion of about one to twelve patients, and they seem up to their work. It has been said that the management reflects credit on the medical superintendent and his staff. This general opinion must be emphasized, while we point out shortcomings. The impression received at Hoxton House is that its affairs are well administered, that the treatment is humane, and conducive to the comfort and welfare of the inmates; but the house is too crowded—as at present occupied—and many of the arrangements are antiquated and call for improvement. There is the greater reason why these defects should be remedied, because the establishment has recently entered upon a new career of superintendence, which promises to be both enlightened and skilful.

IV.—*PECKHAM HOUSE.*

This house was first licensed in 1825. It was not noticed by the Parliamentary Committee of 1827. From "a statement of the number of insane persons in licensed houses on 31st December, 1828, distinguishing those admitted and discharged, or dead, prior and subsequent to the 1st of August, 1828," reported to the Metropolitan Commissioners, January 7, 1829, it appears that at the close of 1828 the house, which then belonged to Messrs. Charles Mott and Co., Dr. Armstrong being the resident physician, contained in all 130 patients. Of these, 18 private patients (12 males, 6 females) and 74 paupers (27 males, 47 females) had been admitted prior to the 1st of August, 1828. Between August 1st and December 31st, 1828, 15 private patients (12 males, 3 females) and 42 paupers (18 males, 24 females) were admitted. Of these, 5 male and 1 female, private patients, had been discharged or died, and 4 male and 9 female, paupers—in all, 19.

In the report for 1844, Peckham House was mentioned with commendation of the site and grounds. The internal arrangements were pronounced satisfactory. The diet, however, was held to be insufficient and poor in quality. In 1847 the Commissioners approved the diet and described the accommodation as, "generally speaking, unexceptionable." They said, "Great improvements and alterations have taken place in this establishment since it was first visited by the Metropolitan Commissioners, and it is due to the proprietor to state that he has never hesitated to attend to our suggestions for the improvement of the asylum, although their adoption has on several occasions involved considerable outlays of money. . . . . The entire cost has been, as we are informed, not less than £11,750."

Whatever may have happened in the interval, there is no reason to doubt the willingness of the present proprietor to carry out any improvement which appears to promise the real advantage of patients, always provided that there is a reasonable prospect of some return. It would be irrational to expect, and therefore absurd to recommend, the lessees of these licensed houses to embark in wild speculation. We have not hesitated to urge the proprietor of Hoxton House to rebuild at least a portion of that property, because, although it may be expedient to remove a part of the establishment to some more commodious site, the need of a licensed house in the present locality is obviously great, and likely to be permanent. The case of Peckham House is not exactly parallel. When the new asylum at Banstead is opened many of the paupers at Peckham will be suddenly removed, and the future is uncertain.

It is impossible, therefore, to deal with this house as we have dealt with others of the class. The *status quo* must be accepted, and little more than moderate improvements can be urged until the future of the establishment is determined by the course of events. That the house will be maintained there can be no question, and while the present mode of meeting the demand for "additional accommodation" finds favour in Middlesex and Surrey, this, like the other metropolitan houses, will be utilized as a receiving station; but it is probable three out of the five will be,

more than heretofore, private establishments, and dependent upon middle-class patients. Until the long-threatened withdrawal of paupers occurs only what is necessary is likely to be done.

Peckham House is situated on the south of the Peckham road, and occupies with its grounds about seven acres of land. It is built in blocks of very different character, some old and almost past patching, others creditably modernized, and a few in thoroughly satisfactory condition, and well suiting the use made of them. There are many single rooms badly lighted, and a few that should be disused, not so much because they are radically defective in construction, as that the impression produced by placing patients to sleep in apartments like prison-cells is disagreeable. There is no room that needs to be summarily condemned, but it would be pleasant to find that some dozen were otherwise appropriated. The dormitories are comfortably arranged, and the beds, although in too many instances of flock or badly matted hair without mattresses, appear suitable to the class of patients for whom they are designed. We certainly think some effort should be made to render the bed itself more comfortable. The pauper patients are, moreover, not well supplied with washing apparatus. They are encouraged to wash in the wards, but the supply of towels did not appear sufficient; and in other respects there is need of greater attention to details, small but important, such as the provision of brushes and combs, and water-bottles for each sleeping apartment. Again we say these will seem very trifling matters to note, but it is, as we have more than once remarked, in little points of detail the working efficiency of an asylum is displayed.

The ordinary day attendants number in the proportion of one to seven patients on the male side, and one to nine on the female. The patients—with a few exceptions in the female department, where slatternly dresses and uncombed hair seemed to indicate neglect—appeared well cared for; and there was no excitement or crowding, although the weather, when our visit was paid, kept the inmates within doors. Only one scratched face, and that on the male side, spoke of a recent encounter of the class which will occasionally occur in asylums. Where these tokens of strife are numerous, it is

natural to infer that either the conditions of life are irritating to the lunatics—by reason of overcrowding and a system of classification in which excitable cases are thrown too closely together—or the personal supervision of attendants is not sufficiently constant and judicious to compose disorder and prevent actual outbreak. It is exceedingly difficult to keep the peace; but where attendants are intelligent and industrious—supposing the superintending officer to exercise personal control and employ his attendants as direct agents in moral treatment — much mischievous mind and brain disturbance, of which these scratches, cuts, and bruises are the recorded marks, may be, and is, prevented by observation and management. There is room for improvement in most institutions, but the general indications at Peckham House convey an impression that the discipline of officials and servants is fairly well enforced.

Restraint is not used, personal watching being substituted. Seclusion is employed, but, we are glad to add, the value of what, for want of a better phrase, is known as the "moral system" of treatment is fully recognized. The practice of surrounding patients with objects of interest; decorating the apartments with pictures, plants, and flowers; inducing the inmates to employ themselves—either in work or play—with something to engross thought and take the mind as far as possible out of itself; and, of changing the scene, by removing a disturbed patient from one ward to another, instead of having recourse directly to seclusion—in a word, the policy of personal treatment—is adopted by the medical directors of Peckham House, and, we hope, carried out with the energy such a system requires and implies. We were informed that something like half the pauper patients are employed. This is a good proportion for a licensed house, though not, as we think, nearly sufficient, looking to the needs of the mental state. Sooner or later the power to make inmates of asylums generally, whether pauper or private, work must be accorded by the legislature. Medical superintendents are, as we have repeatedly urged, at this moment entrusted with the far more dangerous power of placing their patients in bonds and imprisonment. Work is an integral part of "treatment," and until it comes to be

generally recognized in that character the proportion of cases cured cannot be raised to the level indicated by the possibilities of the disease, and the demands of personal, social, and public expediency.

The points to which we would direct especial notice as requiring the attention of the proprietors and directors of Peckham House are neither many nor of a class to call for any considerable outlay. Great improvements have been effected within the last few years. We strongly urge the disuse or reconstruction of certain of the single rooms, particularly those on the ground floor in one block, and a better system of lighting these small apartments generally. Although they are only used at night, it is essential to cleanliness and comfort that they should be well lighted by day. A dark room is seldom thoroughly cleared of foul vapours and impurities. The ventilation throughout the asylum is free, but air-openings near the floor are so constructed that they must be closed in the winter, if not at night all the year round ; and it is when the weather confines patients within doors, and at night especially, that a through current is needed. Some of the closet arrangements are defective, and the use of earth chairs in certain dormitories is necessary to eke out the provision. When it is, on other grounds, desirable to have conveniences of this kind in sleeping apartments—which would seldom be the case if each floor were provided with a decent water-closet — the earth system may be useful, but it is a nasty and troublesome substitute for a well-arranged system of water-closet conveniences.

It ought, we think, to be a preliminary condition of these establishments everywhere that water-closets, constructed on the best plan, should be provided in sufficient number, and on each floor. The addition might be easily made to any block of buildings by running up a small tower at some suitable angle, with closets on each level. It is the more remarkable that this has not been done at Peckham, as in the allied matter of bathing apparatus the provisions are remarkably good, *e.g.* the water being turned into the baths by taps fixed in a cupboard at the side of the room, beyond the reach of patients, the hot and cold water mixing in the supply-pipe. The appliances for bathing are greatly superior to those for washing. The latter require extension and improvement. Mat-

tresses ought to be supplied to all the beds; and where hair is substituted for flock, it should be of good quality and not mixed with wool. At present, the hair beds are as lumpy as the flock. Neither ought to be placed directly on the laths of an iron bedstead, even for paupers.

The clothing of the paupers on the female side of the house is not satisfactory, and, as we have said, their appearance is untidy. It is, of course, difficult to induce the insane to bestow proper care on their attire, and many are destructive; but an effort should be made. This is a matter that must always lie in the hands of attendants, but it is one upon which medical superintendents and directors ought everywhere to insist. When the improvements already in progress are completed, the house will have a cheerful air of comfort, which would be still further increased by attention to the defects upon which we have remarked, together with others which are recognized, and will, doubtless, soon be remedied. The system of treatment pursued at this establishment appears to be judicious and successful.

V.—*GROVE HALL, BOW.*

There is not a great deal to say about this licensed house, regarded from the standpoint of the present inquiry. Although one of the houses receiving paupers, it only contains six, and of these two have been recently admitted. The establishment is exclusively appropriated to the use of male patients, and of these the majority (about 370) are soldiers, the rest being from the middle classes of society, for whom a moderate sum is paid.

The house—with its grounds and a small dairy farm—occupies fourteen acres of land, and is pleasantly situated on the east of the Fairfield road. The buildings are commodious, with considerable cubic capacity, and, looking to the class of patients at present filling the wards, admirably appointed. Soldiers are, under the best of circumstances, a rough set of fellows, and in some parts of the institution the provisions seem somewhat in excess of their requirements. This is, however, a matter which can occasion no regret. It is, however,

impossible to avoid a reflection that Grove Hall might be doing better work than that of a depôt for cases which are nearly all obviously chronic, if not incurable. It must not be supposed from this remark that the inmates generally are of the "quiet" class; on the contrary, it would be difficult to find a body of lunatics calling for more constant supervision and more difficult to control. A great many of the military patients have served in India and suffered from tropical affections, such as sunstroke and fever, while, in several instances, abuse of alcohol and a taint of syphilis form important factors in the disease. The circumstance that order is preserved and tranquillity maintained in the presence of the worst elements of disturbance and an ever-brooding storm, without recourse to physical coercion, and with a minimum of seclusion, is very remarkable, and bears the strongest practical testimony to the success of moral and managerial influences when properly applied.

At Grove Hall, if anywhere, the recourse to restraints might seem to be justified. Although we have very strongly denounced the restraint system, as "a trouble-saving expedient," or a "method employed to avoid risks," it must not be assumed that we are unable to conceive of a case, or circumstances, in which the measure may be inevitable and even expedient. As between the grip of a passionate attendant, and the passive resistance offered by straps or gloves, we should decidedly prefer the latter. It is, at least, certain that mechanical restraints will not exert force in excess of that employed by the patient, although, as we have repeatedly urged, the application of the strait-waistcoat, straps, or gloves undoubtedly provokes the lunatic to struggle for freedom, irritates his brain and nervous system, and exhausts his strength. These are great evils, and must be held to bar the use of restraints habitually, or even as a reserve measure of safety. We would go further and insist that where the system of moral influences is thoroughly developed and applied it will seldom, if ever, be necessary to fall back upon mechanical coercion to insure control. Nevertheless, there are, beyond question, cases of the class Dr. Conolly used to call "spoilt," in which irreparable mischief has been done by the use of violent measures of some kind in the early days of

treatment. Patients of this description form no inconsiderable part of the population at Grove Hall. We have little hesitation, therefore, in claiming it as a proof of the sufficiency of the moral system judiciously employed, that the use of restraints has been, with the single exception of an instance in which gloves were used, almost unknown at this ably conducted establishment.

The proportion of attendants is about one to ten patients. Excellent discipline prevails, and with the aid of an efficient service, a fine laundry, and good working appliances throughout, the general condition is unexceptionable and creditable to all concerned. About half the ordinary inmates are employed, and abundant exercise is secured by military drill. There is a large cricket-ground and a skittle-alley. Walks outside the asylum bounds are frequent. The wards are prettily decorated with flowers, supplied from a conservatory in the grounds. It is needless to go further into details. There is really nothing to notice, save in terms of high commendation. The only subject for regret is that an institution possessing so many structural advantages, so well provided in all necessary particulars as Grove Hall, and so ably and efficiently conducted, should not be utilized for distinctly curative work, of which it is clearly and in a special sense capable.

This concludes our notices of the "Metropolitan Licensed Houses" receiving paupers.

STATISTICAL TABLES.

It is, unfortunately, impossible to obtain the particulars concerning cases treated in the "Licensed Houses" which would be necessary to place them in comparison with those reported from the County and Borough Asylums. The information accessible is indeed exceedingly meagre, and I have only been able to offer a few analyses, which will be chiefly interesting when studied in connection with the statistical summaries and retrospects appended. I have not deemed it worth while to set out the figures for each year, but have contented myself with giving the gross numbers and proportions for the ten years (1865—74) covered by *The Lancet* inquiry.

SUMMARY AND ANALYSIS OF RETURNS FROM METROPOLITAN LICENSED HOUSES RECEIVING PAUPERS, 1865—1874 INCLUSIVE

NAME OF HOUSE, AND NUMBER SPECIFIED IN LICENSE, IN 1865 AND 1874 RESPECTIVELY.	POPULATION. PAUPER AND PRIVATE PATIENTS.										
	TOTAL NUMBER OF CASES ADMITTED DURING THE TEN YEARS.			TOTAL NUMBER OF CASES DISCHARGED DURING THE TEN YEARS.							
	Of all Classes.			On Recovery.			By Death.			Suicide or Accident.	Average number resident.
	Males.	Femls.	Totals.	Males.	Femls.	Totals.	Males.	Femls.	Totals.		
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.
CAMBERWELL HOUSE (1865, 333; 1874, 483; increase 150, or 45·0 per cent.).	807	1063	1870	160	262	422	258	234	492	3	393
BETHNAL HOUSE (400—410; increase 10, or 2·5 per cent.).	808	959	1767	201	298	499	219	192	411	2	361
HOXTON HOUSE (250—325; increase 75, or 30·0 per cent.).	332	901	1233	52	231	283	156	266	422	2	291
PECKHAM HOUSE (320—400; increase 80, or 25·0 per cent.).	783	1070	1853	160	236	396	218	234	452	3	313
GROVE HALL, BOW (410—452; increase 42, or 10·2 per cent.).	975	377	1352	149	122	271	356	122	478	4	416
Total of the five Houses (1865, 1713; 1874, 2070; increase 357, or 20·8 per cent.).	3705	4370	8075	722	1149	1871	1207	1048	2255	14	1774

(*a*) Calculated on the totals of the last six years, the numbers of re-admissions and transfers not being distinguished in the reports of the Commissioners in Lunacy prior to 1869.

(*b*) "New cases" are "Cases admitted" during the period, *less* cases "Transferred from other asylums" and "Relapsed cases re-admitted," both which have been deducted.

ANALYSIS OF FACTS AND RESULTS DURING THE TEN YEARS.

PAUPER AND PRIVATE PATIENTS.

Total number of Cases remaining Decem-ber 31st, 1864 and 1874.	ADMISSIONS.		RECOVERIES.		DEATHS.		Gross proportion per cent. of							
	Gross proportion per cent. of the Sexes.		Gross proportion per cent. of the Sexes.		Gross proportion per cent. of the Sexes.		Recoveries to admissions.	Deaths to admissions.	Recoveries to total number under treatment.	Deaths to total number under treatment.	Recoveries to average number resident.	Deaths to average number resident.	Re-admissions to total number of admissions. (*a*)	Recoveries to new cases. (*b*)
	Males.	Femls.	Males.	Femls.	Males.	Femls.								
XII.	XIII.	XIV.	XV.	XVI.	XVII.	XVIII.	XIX.	XX.	XXI.	XXII.	XXIII.	XXIV.	XXV.	XXVI.
(331/475)	43·16	56·84	37·91	62·09	52·44	47·56	22·57	26·31	19·17	22·35	10·74	12·52	7·09	28·39
(296/396)	45·73	54·27	40·28	59·72	53·28	46·72	28·24	23·26	24·19	19·92	13·82	11·39	8·15	34·53
(243/318)	26·93	73·07	18·37	81·63	36·97	63·03	22·95	34·23	19·17	28·59	9·73	14·50	4·49	29·65
(305/382)	42·26	57·74	40·40	59·60	48·23	51·77	21·37	24·39	18·35	20·95	12·65	14·44	6·84	25·73
(387/437)	72·12	27·88	54·98	45·02	74·48	25·52	20·04	35·36	15·58	27·49	6·51	11·49	4·29	25·27
	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)	(*c*)
(1562/2008)	45·88	54·12	38·59	61·41	53·53	46·47	23·17	27·93	19·41	23·40	10·53	12·71	6·38	28·80

(*c*) All the totals are affected by the circumstance that Grove Hall has for some time past been appropriated exclusively to male, and chiefly military, patients. Omitting this house, the figures at the foot of page 29 will be as follows:—Col. xiii., 40·6; xiv., 59·39; xv., 35·81; xvi., 64·19; xvii., 47·89; xviii., 52·11; xix., 23·80; xx., 26·43; xxi., 20·96; xxii., 22·30; xxiii., 11·78; xxiv., 13·09; xxv., 6·74; xxvi., 29·35.

STATISTICS OF THE METROPOLITAN LICENSED HOUSES.

The following account of an inspection made by Mr. Edward Wakefield * more than sixty years ago was given in evidence before the Select Committee of 1815. It will serve to give a general idea of the condition of matters at that date :—

Private Houses, &c. *Mercurii*, 3° *die Maii*, 1815. The Right Hon. George Rose in the chair. Mr. Edward Wakefield again called in and examined.

What private houses have you visited within the Bills of Mortality?—The first house I applied to see, was kept by Peter Gilles Briant, at Gore House, Kensington, who refused letting any person see a patient within his house, or the house itself, or any thing in it. The next was kept by a person of the name of Pearce, at Chelsea ; in that house there were four patients only, all of whom I saw ; they were idiots, without any coercion ; the house generally dirty ; but otherwise, from the superficial glance I had of it, I saw no reason to find any fault with it. The next place I went to was Norman House, at Fulham ; this was a house kept by a man of the name of Talfourd, for females only ; there were in it fourteen ladies, all of whom I saw, and was delighted with the manner in which they were treated, and with the degree of happiness which they appeared to enjoy ; I remained with them nearly two hours ; conversed with every individual ; and could not find, that either hand-locks or leg-locks were ever used : Some of them stated, that they frequently went to church, that they attended a fair in the neighbourhood (Brook Green fair) ; and two had walked to Walham Green, to see Louis XVIII. I think it difficult to speak too highly of Norman House generally ; I believe there was no man in the house, except the husband of the woman who kept it, and there was the greatest kindness towards the patients. I next visited Mr. Fox's, London House, Hackney; this is a house that I think admirably conducted : Mr. Fox himself is an apothecary, living in Norton Falgate, and it is managed by his wife, who is a judicious good-natured woman, whom all the patients seemed very much to respect ; every time that I was there, Mr. Tilley Matthews was living, and in point of fact was the advising manager of the conduct of the patients in that house ; it is a large house, capable of the sexes being kept distinct and separate, and they were here classed, according to their habits in life ; one lady, who conceived herself to be Mary Queen of Scots, acts as preceptress to Mr. Fox's little children, and takes great pains in teaching them French, etc.

Are the patients in that house roomily accommodated?—Quite so ; they are not crowded.

Are the violent kept from the more placid?—Yes, they are so ; I saw none violent ; indeed, *I believe the violence in general is, more or less, according to the treatment.*† I visited that house a dozen times at least, and Mr. Matthews took me over every part of the house, and told me the case of every patient. I visited Talbot's (generally called the White House) at Bethnal Green ; this is a large house, chiefly occupied by parish paupers ; I arrived there just at their dinner-

* See vol. i. page 288.

† This just opinion was expressed, be it remembered, more than half a century ago.

time; I tasted the pudding and the meat, and saw the rations, as they may be called, of each individual served out, and thought it all excellent; it is a house in which there are nearly 300 patients.

Do you know the prices received for the parish paupers?—I have heard that the terms were 10s. a week, but now 9s. 6d.; the house is well ventilated constantly, and white-washed; at the time of day that I was there, all the patients, except one or two under bodily disease, were up, and downstairs; the chamber windows were all thrown open, the bedclothes of the male patients turned halfway down during the day. The wet or dirty patients sleep upon straw, on a bedstead in the shape of a trough; from those bedsteads the straw was emptied, the bedsteads raised up from where they stood at night, standing on one end; there were chains on the sides of many of those bedsteads, and I understood the patients were leg-locked or arm-locked of a night; and perhaps it proves the restraint under which even these patients live, that the keeper, Mr. Talbot, stated to me, that a patient knowing himself to be leg-locked, seldom flew into those paroxysms which he would do without that. The house is a building ill-constructed for the purpose; but at the time of the year that I was there (the month of May) the patients were all out in the yards; it was a fine sunshiny day; I apprehend, that in winter time, when they are obliged to be under cover, the day-rooms must be excessively crowded; from the view which I had of it, my opinion is, that the treatment is as good as the man is capable of giving to such persons in such a building. . . . .

Adjoining this house there is another large establishment, called the Red House, kept by a man of the name of Rhodes; but in point of fact, I believe, like the last, that it belongs to Mr. Warburton. The Red House is the only private establishment that I know of within the Bills of Mortality, which has been built for the express purpose of keeping the Insane; the greater part of the house is devoted to patients of a superior class, the female and male part of the establishment being divided at the staircase; there were some ladies whom I saw at dinner; there were panes of glass in the two upper panels of the door out of the gallery, which enabled the keeper to inspect them without their being aware of the inspection. The wings are occupied by pauper patients; the sexes perfectly distinct from each other, the whole centre of the house, and the large garden, dividing the two wings; the management of the pauper patients appears to me to be as similar to that of those at Talbot's as it is possible to be.

Is there the same management as to the beds, exposing them to ventilation during the day, as there is at Talbot's?—Yes, just the same; the airing grounds are infinitely too small for the number of patients; on the day I was there, being a particularly fine day, when they were all locked out of doors in the fresh air, still they were huddled together in one mass like a flock of sheep. I applied at Sir Jonathan Miles' receiving houses at Hoxton, for leave to look over them; Mr. Watt, the person who had the care of that house (Sir Jonathan Miles not living there) stated, that it was in the hands of trustees, who had determined that no person should be permitted to look over the buildings; I argued with him the injury that he might do himself from such a refusal, and his answer was, that an inspection of that house would be signing its death-warrant.

Do you know whether that is the house in which the naval Insane patients are received?—It is. The next I went to was kept by Mrs. Burrows, a widow, and her son, at Hoxton; this is an old house extremely inconvenient for the purpose; but still the parish paupers are kept distinct from patients who pay at a different rate, and there are several attempts at classification; at the end of one of the yards, there is a distinct building for the male parish paupers; the general treat-

ment I conceive to be like that of the other houses where they take parish paupers. I examined some of the men in a convalescent state, as to their food, who stated in the strongest way, that they had plenty; the rooms had been all mopped down as they were at Talbot's; there were the same sort of trough beds, where some patients were chained in the night.

Were the patients generally well treated?—I believe so: I have been at Mr. Warburton's at Hoxton, but not over the whole house, for want of time; at this establishment there are very large gardens; some of the patients pay rather liberally; and in those gardens are many small distinct houses, and I wish to draw the attention of the Committee to the great benefit of these distinct houses; the great enjoyment which a patient who has the means of paying for it, receives from living in a small house, surrounded by a garden, without the noise or the annoyance of violent maniacs about him. I visited a house in Kingsland where the name of Glanville is upon the door, but the woman who kept it stated to me, that that was not her name; in this house were four patients, three women and one lad, all in or on their beds, in rooms without any ventilation, and almost more offensive than any thing I ever put my head into.

. . . . I have seen two houses in Somer's Town; in one of them, the male patients were all in one day-room; there were about seven or eight in number; the room was extremely close and offensive; the garden and the upper part of the house being occupied by 14 or 15 females, who were chiefly French; it appeared to me that the house did very well for the ladies, for the purpose of accommodating them; the men were all stuffed together. . . . . In the other house there were only five or six patients, all nearly idiots; and I thought they were under the care of a good fatherly kind of a man; the house was generally sweet and clean, and I saw nothing to find fault with there. I called on Doctor Monro, in the Adelphi, and asked his permission to see Brook House, Hackney; he politely said that I should be quite welcome, provided I could get the leave of the friends of each of his patients; knowing the thing to be impossible, not knowing who the patients were, I made no further effort. I applied at Fisher House, Islington, which belongs to Doctor Sutherland; the housekeeper refused to let me see any part of it; but in justice to Dr. Sutherland, I must state to the Committee, that he has since desired me to call and look over every part of it; I have not done so.

In these several houses, had you the means of learning what medical assistants attended occasionally?—Many of these houses belong to physicians, or they had a share in them, and attended them of course.

Did you learn whether these houses had been visited by the Commissioners?—That was a question I invariably put at every house, and I think it was generally answered, that they were seldom visited; but I am not aware of any house that the Commissioners had entirely neglected. In those private houses, where parish paupers are kept, I have had great complaints made against the parishes for not providing their poor with sufficiency of clothing. In closing the account which I have given of houses of this sort within the Bills of Mortality, I beg to say, that I have been received with great civility by many keepers of Private Houses, and the public institutions of Saint Luke's and Guy's Hospitals; and that the general feeling which I have upon the subject is, that there is great merit due to many individuals for the humanity which they exercise to the unfortunate persons under their care; and that I should be very much hurt, if any observations that I made in any place should tend to injure the character or the business of a keeper of a Madhouse.

The picture presented by this Report may be conveniently examined in connection with that sketched by *The Lancet* commission. The comparison will at least make it apparent that many of the defects noticed to-day were pointed out more than half a century ago, and are still without remedy.

"A Return of the Number of Houses .... Licensed for the Reception of Lunatics," etc., presented to the House of Commons 4th May, 1819, gives the following particulars :—

Counties and Number of Licensed Houses.	Names of Persons to whom the Licences are granted.	Number of Patients confined in each House.		
		Males.	Fmls.	Total.
Middlesex.				
3 at Hoxton	William Burrow, Esq.	61	57	118
6 at Hoxton	Sir Jonathan Miles	199	149	348
1 at Hoxton	Thomas Warburton, Esq.	47	31	78
1 at Blacklands, Chelsea	Mary Bastable	14	11	25
1 at King's Road ,,	Mary Bradbury	—	4	4
1 at King's Road ,,	George Man Burrows, Esq.	4	6	10
1 at King's Road ,,	Jane Jones	—	11	11
1 at Church Street ,,	William Press, Esq.	1	2	3
1 at Little Chelsea	Elizabeth Reedford	3	7	10
1 at Beaufort Row ,,	Robert Salmon, Esq.	5	3	8
1 at Lower Street, Islington	James Annandale	13	7	20
1 at Kingsland	William Bignall, Esq.	1	2	3
1 at Kensington Gore	Anna Maria Briand	9	7	16
1 at London Lane, Hackney	Samuel Fox, Esq.	11	14	25
1 at Hackney	George Rees, Esq., M.D.	10	9	19
1 at Turnham Green	John Thompson Jackson, Esq.	2	1	3
1 at Brook Green, Hammersmith	Thomas Maynard Knight, Esq.	2	5	7
1 at Paddington	William Langdon, Esq.	—	3	3
1 at Clapton	Edward Thomas Munro, Esq., M.D.	19	22	41
1 at Weston Place, Pancras	James Pell, Esq.	—	10	10
1 at Somer's Place, Somers-town		5	1	6
1 at Winchmore Hill	Phœbe Richardson	—	4	4
1 at Hillingdon, near Uxbridge	James Stilwell, Esq.	2	3	5
1 at Walham Green, Fulham	Edward Talfourd, Esq.	—	17	17
3 at Bethnal Green	— Rhodes, Esq.	146	169	315
3 at Bethnal Green	— Talbot, Esq.	241	241	482
Surrey.				
1 at Guildford, called Leepale House	Thomas Hills, Esq.	1	1	2
1 at Chertsey, called Weston House	J. Lucett, Esq.	—	3	3
1 at Frimley	Robert Stracey Irish, Esq.	2	1	3
1 at Thorpe, called Great Forster House	{Charles Summers, Esq. / Thomas Phillips, Esq.}	12	6	18
1 at Lower Tooting	Ann Sandiford	2	5	7
42 Houses.	31	812	812	1624

It does not appear how many of the 1624 were pauper patients. From a return ten years later, it seems that on December 31st, 1828, there were within the jurisdiction of the Metropolitan Commission thirty-five establishments, licensed to as many persons, and containing 2031 patients, of whom 1154 were pauper and 877 private patients. In 1875, notwithstanding the provision for pauper lunatics in county asylums, which, as we have seen, did not exist at the period to which these returns relate, there were forty "Metropolitan Licensed Houses," licensed to

sixty-four persons, and containing 2761 patients, of whom 943 were pauper and 1815 private; and two houses in Surrey, licensed to four persons, with twelve patients.

On the 15th of June, 1840, Lieut.-Col. Sykes, F.R.S., vice-president of the Statistical Society of London, read a paper on the "Statistics of the Metropolitan Commission in Lunacy," which should be studied, even after the lapse of thirty-seven years, by all who desire to master the history of asylum work. The following is an abstract of the salient particulars :—

Forty-two asylums have been under the supervision of the Commission since its first establishment. Some slight changes have taken place, in the abandonment of two or three establishments, and the addition of others. The number in existence on 30th of May, 1839, was thirty-four, the numbers of patients in which varied from two to above three hundred.

The total number of patients who have appeared on the books of the several asylums under the Commission, since its establishment, exclusive of last year, is 7460, comprising 1817 male paupers and 2098 female paupers, 1994 male private patients and 1551 female private patients; the gradually increasing confidence of the public being manifested by the increase of the patients in the asylums from more than 1400 in 1832–3, to more than 1700 in 1838–9. Of the above number of 7460 lunatics, 4021 have been discharged or removed, between the 31st of August, 1832, and the 31st of May, 1839, viz. 917 male paupers and 1088 female paupers, 1128 male private patients and 888 female private patients. Unfortunately, with the exception of the first two years, the forms of the returns do not distinguish, amongst the discharged, the cured, relieved, or removed (uncured) by relatives or friends; no satisfactory deduction, therefore, can be obtained of the chances of recovery of insane persons. With regard, however, to the annual proportion of discharges, it may be stated that 25 per cent. of the male and 23 per cent. of the female, paupers, with 24 per cent. of the male and 22 per cent. of the female, private patients, were annually discharged, the private patients being in each case 1 per cent. less than the paupers, and the females in each case 2 per cent. less than the males. It is satisfactory to be able to state that the proportion has very materially increased of late years. On the average of the two years 1832–3 and 1833–4, the discharges, both of pauper and private patients, amounted to 21 per cent.; in 1838–9 the discharges of the former had increased to 28 per cent., and of the latter to 31 per cent. . . . .

The admissions for six years, between the 31st of May, 1833, and 31st of May, 1839, were 5386, and the average annual number of patients under treatment on the 31st of May, for seven years, was 1611, namely, 313 male paupers, 449 female paupers, 446 male private patients, and 402 female private patients. It is worthy of notice and of further enquiry, that the number of female paupers exceeds that of the males by one-third, while the number of female private patients falls short of that of the males by a ninth.

I come now to the most marked and, I regret to say, the most melancholy feature of the statistics of the Commission—the percentage of deaths in the different sexes, and in the two great classes into which the patients are divided—pauper and private. The annual percentage proportion of deaths for the whole period among the whole number of patients is 10·13; but this average exhibits a wide discrepancy when the percentage upon the paupers and private patients is taken separately. It is then found that the deaths of paupers amount to 12·76 per cent., and of private patients to only 7·56. And, if the males be separated from

the females, it will be found that the male pauper deaths average 15·52, and the females 10·61 per cent.; while the private male patients average 8·73, and the female private patients only 6·18 per cent. The same differences run through the several years with pretty general uniformity, although the male pauper deaths, in the year 1836–7, amounted to 17·54, while in 1833–4 they did not exceed 12·16, and in 1838–9 amounted to 12·29 per cent. The highest annual average of the female pauper deaths was 12·90 in 1836–7, and the lowest was 6·62 in 1833–4, but 11·34 in 1839, when the proportion of male pauper deaths was 12·29. The average proportion of pauper deaths of both sexes to the total number of pauper patients is 12·76 per cent. Amongst the deaths of private male patients the highest annual average was 11·56 in 1836–7, and the lowest 7·22 in 1835-6; 1833–4 and 1838–9 being almost equally low. Amongst the private female patients the highest annual average was 7·65 per cent. in 1832–3, and the lowest, 4·70 per cent., was in 1835–6. In 1838–9 the average only amounted to 5·21 per cent. The year 1836–7 was one in which, I believe, influenza prevailed, and in which the winter was unusually severe; it proved proportionally fatal to both classes of patients.

The average of all the years produces the following results—that the proportion of deaths amongst males in both classes of patients is considerably greater than amongst females, namely, 11·73 per cent., while that of deaths of females is only 8·49 per cent.; but that the deaths of paupers, male and female, exceed those of private patients in the relative proportion of 12·76 and 7·56, namely, 68 per cent.; therefore, *for every hundred paupers dying, only 59¼ private patients die.* This fearful discrepancy is a matter for serious reflection, and demands careful investigation.

The following tabular statement embodies such particulars as it has been possible to collect from the reports of the Commissioners in Lunacy, in relation to the proportional death-rates of pauper and private patients in Metropolitan Licensed Houses during the year 1875:—

	Total Patients under treatment during 1875.			Deaths in 1875.			Percentage of deaths to total number under treatment during 1875.		
	Males.	Femls.	Total.	Males.	Femls.	Total.	Males.	Femls.	Total.
Pauper and private patients.....	1822	2099	3921	161	137	298	8·84	6·53	7·60
Pauper patients.....	481	980	1461	63	74	137	13·10	7·55	9·38
Private patients.....	1341	1119	2460	98	63	161	7·31	5·63	6·54

Taking equal numbers of the pauper and private patients under treatment during 1875, we find 143 pauper patients died to each 100 deaths of private patients. Separating the sexes, the proportions were 179 male paupers to each 100 male private patients dying; and 134 female paupers to 100 female private patients. Therefore, to every 100 deaths of pauper patients, only 70 private patients died; to 100 male pauper deaths, only 56 private male patients died; and to 100 female pauper deaths there were 75 deaths of private female patients. These facts are of momentous significance. They do not, to my mind, receive adequate explanation from the social advantages, or more healthful previous history, of the favoured class.

Dr. Farr's "Report upon the Mortality of Lunatics," read before the Statistical Society of London, 15th March, 1841, and elsewhere cited, contains the following remarks on the paper by Colonel Sykes :—

This report, which has been drawn up at the request of the council of the society, is formed on the reports of the Hanwell Asylum, returns from the Bethlem Hospital, and the valuable series of tables submitted to the society last year by Colonel Sykes. It was thought desirable that the mortality of lunatics in two of the largest public institutions of the country should be compared with the mortality in the licensed proprietary houses; and that, if the mortality differed, the differences should be investigated, and traced to their causes, by the methods of statistical analysis which we now possess.

The table below gives the number and distribution of "lunatics and dangerous idiots under confinement in Middlesex, and in the parts of Surrey and Kent within the jurisdiction of the Metropolitan Commission," in 1839.

	Males.	Females.	Total.
In the Asylum at Hanwell.....	346	488	834
,, Bethlem Hospital	148	151	299*
,, St. Luke's ,, ...	104	136	240
,, Guy's ,, ...	—	24	24
,, 34 Licensed Houses.....	787	926	1713†
Total.....	1385	1725	3110

After detailing the statistical experience of Middlesex, Dr. Farr continues :—

Let us now compare the facts observed in the Hanwell Asylum with those submitted to the society by Colonel Sykes, relative to the lunatics in licensed houses within the jurisdiction of the Metropolitan Commission. Colonel Sykes's returns have been analyzed according to the same methods.

	Total number Discharged.	Discharged as Cured or otherwise.	Died.	Deaths in 100 Cases.
Licensed Houses, from 11th August, 1832, to 31st May, 1839.....	5747	4021	1726	30·0
Hanwell Asylum, from 16th May, 1831 to 30th September, 1840, ...	1171	515	656	56·0

The deaths to a hundred *cases* were more numerous in Hanwell than at the licensed houses; but, in the *annual mortality* per cent. the proportions were reversed :—

	Years of Residence.	Died.	Annual Mortality per cent.
Licensed Houses, from 30th June, 1833, to 31st May, 1839.....	9671	1504	15·5
Hanwell, from 16th May, 1831, to 30th September, 1840	5498	656	11·9

The annual mortality per cent. at Hanwell was to that at the licensed houses as 100 to 130. For various reasons the patients remain longer in the Hanwell Asylum than in the licensed houses, from which 37 per cent. were annually discharged alive; while 9·4 per cent. were discharged annually, cured and relieved, from the county asylums. The number admitted during the six years, June,

"* Exclusive of 16 out on leave."

"† 459 men and 419 women in the Licensed Houses are not paupers."

1833–39, into the licensed houses was 5386; making 278 more than 5108, the number discharged by death, recovery, or otherwise. There were 1435 in the licensed houses on 30th June, 1833, and 1713 on 31st May, 1839. The number of inmates had increased 19 per cent., and, notwithstanding the erection of Hanwell, the increase bore principally upon paupers, for 202 of the 278 were paupers.

MEAN TERM OF RESIDENCE.

	Years of Residence.	Number Discharged.	Mean Term of Treatment.
Hanwell (1831–40)	5498	1171	4·48
Licensed Houses (June, 1833–9)	9671	5108	1·89

The lunatics in the licensed houses are divided into two classes—paupers, and other patients belonging to the independent classes of society. It will be right to compare the paupers in the licensed houses with the paupers in Hanwell, and, for this purpose, to separate the paupers from the other class.

LICENSED HOUSES—SIX YEARS, JAN., 1833–39.

	Paupers.	Others.
Admitted	2939	2417
Discharged	2737	2371
Died	947	557
Years of residence	4580	5090

The comparative mortality was as follows :—

	Annual Mortality per cent.	Deaths out of 100 Cases discharged.	Mean Term of Treatment in Years.
Paupers in Licensed Houses	21	35	1·67
,, Hanwell	12	56	4·48
Other patients in Licensed Houses	11	23	2·15

The annual mortality of paupers in the licensed houses is thus shewn to have been excessive.

I proceed to compare the mortality of the male and female paupers at Hanwell, and in the licensed houses, with that of the other class of lunatics :—

IN THE LICENSED HOUSES, JUNE, 1833-39.

	Paupers.		Others.	
	Men.	Women.	Men.	Women.
Admitted	1419	1520	1419	1028
Discharged	1343	1394	1365	1006
Died	504	443	353	204
Years of residence	1882	2698	2677	2414

From these facts the following results have been deduced :—

	Annual Mortality per cent.		Deaths out of 100 Cases Discharged.		Mean Term of Residence in Years.	
	Males.	Females.	Males.	Females.	Males.	Females.
Licensed Houses :						
Pauper lunatics	26·8	16·4	37·5	31·8	1·40	1·93
Other lunatics	13·2	8·4	25·9	20·3	1·96	2·41
Hanwell	16·0	8·9	58·5	53·0	3·65	5·94

It will be observed that the annual mortality of both male and female paupers in the licensed houses was *nearly twice as great as the mortality of paupers at Hanwell, and twice as great as the mortality of other lunatics in the licensed houses.*

Pauper lunatics were received at six licensed houses during the term over which Colonel Sykes's returns extend. . . . .

The paupers remain little more than a year and a half (1·67) in the licensed houses, in which the annual mortality was 21 per cent. ; at Hanwell the annual mortality in the first year and a half after admission was 18 per cent.

Dr. Farr observes :—

The returns from the licensed houses do not state the ages; and the ages of few lunatics are given in the interesting report of Dr. Conolly. From other observations it is known generally that the mortality increases, and that the probability of recovery declines, as age advances. . . . .

The influence of complications of sex, and of age, may be assumed to be nearly the same in the licensed houses and Hanwell, as in ordinary asylums—the asylum, for instance, at Gloucester, where the mortality does not exceed 7 per cent. annually.

Dr. Thurnam, in his "Observations and Essays on the Statistics of Insanity," published in 1845, comments upon the paper by Col. Sykes, from which we have been quoting. He says :—

In the Metropolitan licensed private asylums it appears, from the facts collected by Colonel Sykes, that during the six years 1834–39, the mortality was at the extremely unfavourable rate of 20·68 per cent. amongst paupers, and at the very high one of eleven (10·94 per cent.) amongst private patients. *From such results our inference can hardly be otherwise than unfavourable to many of these establishments.* In the return for these asylums, for the five years 1839–43, recently given by the Metropolitan Commissioners, the separation of private and pauper patients is not complete ; but it is sufficiently so for us to perceive that amongst private patients, at least, the mortality has undergone a material diminution : it is now only 6·8 per cent. Amongst paupers we must conclude that the mortality remains at the same fearfully high rate, it being 18·1 per cent. in the three houses which receive paupers and one-fourth of private patients; and in one of these houses, containing about four hundred patients, of whom one-fifth are private patients, the mortality amounted to 20·66 per cent., and was doubtless still higher amongst the paupers. It is to be remarked that, while the mortality during the same period of the Provincial licensed asylums for private patients, of 6·57 per cent., corresponds very closely with that of asylums for the same class in the Metropolitan district, there is an extraordinary disproportion as regards paupers, unfavourable to the Metropolitan houses; for whilst in asylums within this district, receiving paupers and about one-fourth of private patients, the mortality, as we have seen, was 18·1 per cent., in Provincial houses of the same class, primarily for paupers, and receiving private and pauper patients in the same proportion, the mortality did not exceed 10·56 per cent.—being an excess of more than 71 per cent. on the side of the Metropolitan houses. Amongst the remediable causes of a high mortality amongst the pauper insane, I believe the *most important, and perhaps most prevalent, are a too scanty and innutritious diet, and insufficient fresh air and exercise.*

GENERAL REMARKS ON "METROPOLITAN LICENSED HOUSES" VISITED.

THIS commission being at present chiefly concerned with the insanity of paupers, and the inquiry restricted to the provisions made for the counties of Middlesex and Surrey, and the city of London, the "Metropolitan Licensed Houses" receiving paupers have alone been visited. The peculiar position of these establishments was explained in the introductory paragraphs of the report on Camberwell House, the first inspected.

There is not a great deal to add to what has been already noted in connection with the several institutions of this class. It is obviously impossible to enforce demands, like those made on public bodies, upon the proprietors of private establishments, because it would be unreasonable to expect men engaged in a commercial venture to ignore their financial interests. Justices of counties and corporations of cities and boroughs can have no legitimate object beyond the administration of public money with wise economy. When it is contended they err, the allegation reflects on the acumen of an executive body; there can be no question of interested motives. Committees may, indeed, court passing popularity by a short-sighted parsimony, or yield to the pressure of a temporary need; but this seldom happens.

The mistakes made by justices are almost invariably errors of judgment on the point of expediency, or spring from some misconception of facts. They do not look sufficiently far ahead to perceive the folly of spending a pound to-day with the certainty of being compelled to incur a similar outlay in the near future, when the expenditure of thirty shillings now would obviate further expense, and save ten shillings on the total disbursement; or, they are so strongly imbued with an idea of their own imagining, that counsel is unasked and warn-

ing disregarded. Such being the sources of error, it is a public duty to speak plainly, and to insist strongly on the consideration of the arguments submitted with a view to modify the policy pursued.

The position of a critic who presumes to express an opinion on the management of private establishments is widely different. The remonstrance addressed to proprietors may be based on the general ground of humanity, but it must be shown that any reform recommended is consistent with the immediate or ultimate interest of the commercial investor, otherwise the appeal will not deserve, and cannot possess a valid claim upon, his attention.

If grave grievances existed, or the conditions extant pressed injuriously on the pauper inmates of licensed houses, it would be necessary to advise the removal of these patients; but the remonstrance would need to be addressed to the justices, who are their legal guardians. There is no *locus standi* for a censorship of private houses—beyond that which may be based on the public law or general considerations of expediency—and it would be for the Commissioners in Lunacy to exercise that function.

A commission representing the medical profession, in the name of one of its organs, can only appeal on grounds of professional prudence to the members of its own body, who are responsible for the administration criticized. It is expedient to define the position thus carefully, because no good work is likely to be accomplished, and misconception may arise unless the aim and scope of our remarks are clearly recognized.

It has been satisfactory to find nothing at the metropolitan licensed houses that would suggest an appeal to the public authorities responsible for the protection of their pauper inmates. The defects and shortcomings we have felt called upon to notice are, without exception, matters which may form the subject of discussion with the medical superintendents or proprietors. The physicians and surgeons concerned, in some instances—as at Camberwell, Peckham, and Grove Hall—are also proprietors, and the recommendations urged need therefore scarcely be separated.

It will, however, be convenient in all cases to bear in mind that the skill of the workman and the fitness of his

tools are essentially different matters, although correlated in the production of the result. Occasionally, it may be, the expert gains reflected credit from the insufficiency of the means with which he is able to carry on a great work. This can seldom happen in lunacy practice; and it is especially important to insist that, in this department of enterprise at least, the workman is not only justified, but duty compels him to seek protection from personal responsibility, in a strong and clear protest against any serious defect of the appliances placed at his disposal. Nor is it enough to protest in words: deeds must follow.

The rule prudence and humanity prescribe for the guidance of medical officers in every service applies with peculiar force to the conduct of physicians and surgeons engaged in asylum practice. No man can be excused for retaining a position of responsibility in an organization which does not enable him to discharge his professional obligations to the patients intrusted to his care. This is a matter of great moment, and one that should be pressed upon the consideration of medical officers and proprietors generally.

It is the more easy to urge this point, because, as we have said, there is nothing so serious in the defects noticed at the licensed houses visited as to render an appeal to public authorities necessary. Meanwhile, there are matters of grave concern—for example, crowding, deficient air-space, especially in sleeping apartments, and other important faults or evils, in some instances demanding for their remedy the disuse of rooms, the constructive alteration of blocks and houses, the redistribution of patients, and the provision of better furniture and improved appliances—to which we have alluded in terms of temperate remonstrance, that must, nevertheless, be distinctly understood to require immediate attention.

It is incumbent upon the medical officers of these establishments to give the matters mentioned their urgent consideration, and upon proprietors to carry out their recommendations. In respect to certain of the suggestions thrown out by this commission, a wise and practical course has already been taken. At Camberwell House, for example, many of the defects pointed out in *The Lancet* report have been remedied. In this instance we had the advantage of a direct appeal to

the medical proprietor, and he has responded in a manner which gives promise of still greater reforms. It is pleasant to place this fact on public record, and it must go far to confirm confidence in the establishment named. We shall be gratified to hear that the same policy has been adopted in other instances.

Whatever may be the ultimate success of this inquiry, its immediate intention will be fulfilled if the position of medical superintendents and officers in public and private establishments is more clearly recognized. In times past, it is to be feared, the nature and limits of the responsibility resting upon medical officers have not been adequately defined. It may be that the purpose and the conditions of professional practice have been misunderstood, and the endeavours of men striving earnestly and honourably in the interests of science have been hampered, instead of being supported, by the criticism to which they have been exposed. This is an occasion for deep regret. It remains to show that the profession has a keen and practical interest in their labours—that it can appreciate the difficulties which surround them, and will help to remove the obstacles that impede their progress. This, we are convinced, is the feeling of the great body of practitioners, and it only needs to throw down the wall of partition between the specialty and the profession that the sentiment may express itself in action.

Medical superintendents and medical officers of asylums, hospitals, and licensed houses must not be left to fight the battle of humanity and progress alone, nor should the demand for reform and improvement be urged as though the medical men engaged in lunacy practice were themselves obstructive. The remonstrances of this commission are addressed to committees of justices and proprietors of licensed houses in the name of the medical profession, and they are submitted to the superintendents and officers of these institutions as the representatives of medical opinion in an important branch of practice. With this aim, and in this spirit, the suggestions and recommendations urged in the course of these reports are now left to the judgment of the physicians and surgeons holding positions of responsibility in the institutions visited, and it remains at their discretion whether they shall be supported and enforced.

REPORT OF "THE LANCET" COMMISSION ON LUNATIC ASYLUMS, 1875-6-7.

THE purposes of this inquiry, as stated in *The Lancet*, December 4th, 1875, and the conclusions reached by investigations carried down to the present date, may be summarized as follows:—

1. To ascertain the general character and efficiency of the provisions made for the INSANE IN ASYLUMS, and the conditions of their daily life.

Five asylums provided by the county authorities of Middlesex and Surrey have been visited, namely, the Middlesex Asylum at Hanwell, which was opened in 1831; the Surrey Asylum at Wandsworth, dating from 1841; the Middlesex Asylum at Colney Hatch, from 1851; the Asylum for the City of London, at Stone, established in 1866; and the second asylum for Surrey, at Brookwood, opened in 1867.

The third asylum for Middlesex, recently erected at Banstead, has not been visited, as no judgment could be fairly formed on the subject of its efficiency until, at least, some months subsequent to the admission of patients.

The Royal Hospital of Bethlem, the Hospital of St. Luke, and five of the Metropolitan Licensed Houses, which receive pauper patients, have been inspected.

It has also been deemed expedient to visit the Metropolitan District Asylums for incurables, although these are classed as "workhouses" under the Act of Parliament, and their inmates are neither confined under certificates of insanity, nor directly supervised by the Board of Commissioners in Lunacy. It was not, however, considered within

the scope of the inquiry to inspect the workhouses, in which only imbecile paupers can be *legally* detained.

The "general character" of the provisions made for the insane in these institutions has been indicated in the several reports, which have dealt with the leading features of construction and arrangement. The conditions of the daily life of patients have been set forth as completely as the circumstances would permit, noting chiefly the points to which it seemed desirable to direct attention as requiring amendment.

The "efficiency" of the accommodation provided and arrangements made, has formed the subject of detailed comment as each establishment passed under review. It now remains to say, generally, there is much that calls for reform in the establishments inspected, more particularly the asylums. Their present use, as we have pointed out, looking to the medical and economical considerations involved, amounts to a misappropriation of space.

In what manner and to what extent this mistaken use of the provision made affects the well-being of the insane, has been explained in the reports; it must be furthur urged that the permanent interests of the ratepayers sustain serious injury, by the neglect of local authorities to provide prompt and rapid cure for the curable, so as to produce the greatest number of recoveries in the shortest time, with the least possible increase to the total of chronic cases which must be permanently maintained. The obvious measures to this end are (1) the construction in each district of an effective hospital for the treatment of recent cases, and (2) the provision of separate accommodation for incurable cases in supplementary institutions either under different control, or the same management, but detached.

There has, for some time past, been a block in the asylums, consequent upon the accumulation of old cases rather than the admission of new, that is recent, cases. It is not desired to offer any opinion on the general question whether insanity increases, but it is expedient to ask especial attention for the undoubted fact that the evidence upon which the hypothesis of increase mainly rests is the presence of an enormous number of patients in asylums, only 5·10 per cent. of which were "deemed curable" by the medical superintendents of

asylums for Middlesex and Surrey at the close of 1874. Forming our own estimate of the proportion of curable cases admitted, we believe that less than one-half of the total admissions during the ten years to which the inquiry relates, presented physical and mental characteristics of a nature to justify their presence in curative institutions. This circumstance points to the gravity of the situation, and the fallacy of the policy in force. It is easy to see that if old and hopeless cases are crowded into hospital beds, and patients obviously incurable are not removed, the number "under treatment" must continue to increase, although the proportional number of new cases occurring in the general population may not be augmented.

2. To discover the measures, and, as far as may be possible, to formulate the system of TREATMENT adopted for the cure of remediable, or recent, and the relief of incurable, or chronic cases.

It has been found impossible "to formulate the system of treatment" either for cure or relief. Practically, there is no general "system," beyond that which may be described as control, effected by moral or, in very exceptional cases, physical restraints.

The so-called "non-restraint system," in its purely negative aspect, obtains generally, and mechanical appliances for coercion are not employed unless special reasons, for the most part surgical, compel its use. "Seclusion," under its mildest form, prevails; but even this is falling into disfavour with medical superintendents, who find that the maintenance of order by good management, and the occasional removal of excited or irritable patients to another ward, will generally obviate the recourse to more forcible measures.

The use of depressing remedies is almost discarded by the most experienced and successful physicians, although modern theories as to the action of digitalis have somewhat delayed its dismissal. Opiates, and the narcotic drugs generally, are neglected, and sleep is found to be readily obtained by the judicious ordering of such matters as light and darkness, heat and cold, ventilation and, above all, food. The use of cold baths, especially shower and douches, is restricted to medical

purposes. Good results have been gained by the Turkish bath; as mentioned in the report on Colney Hatch.

On the subject of food we have a special statement to make, and it is one of extreme moment. No diet scale in use is up to the level of the requirements for "*moderate exercise*," as set out in Dr. Lyon Playfair's tables, which, it will be remembered, were based on experiments of food taken, and are, therefore, of higher authority than any mere theoretical estimates could be. This is a most important fact, and it derives additional significance from the discovery that the diets now in force at Hanwell and Colney Hatch Asylums are actually lower in calorific and work value than the tables in use at the same institutions in the year 1853. Diet is, beyond question, a prominent element of treatment; therefore we speak of it in this connection.

A misconception seems to exist in the minds of visiting committees as to what constitutes treatment, and this is to some extent maintained by the system of returning certain cases as "under medical treatment," as though the *régime* and management of patients suffering from mental disease were not medical throughout.

It has been strongly contended in the reports that asylums are so large as to render the personal treatment of their inmates impossible. This opinion must be emphasized here, and it is one of the reasons why the policy of substituting *hospitals* for asylums is recommended.

3. To collect and collate statistics of cases occurring within the last ten years at the asylums visited, with a view to estimate the RESULTS.

The total number of patients treated at the five asylums, during the ten years 1865–74, was 17,966—of which 4124, or 22·95 per cent., recovered; 3065, or 17·06 per cent., were discharged "relieved or not improved;" and 4996, or 27·81 per cent., died.

The recoveries were 30·51 per cent. of the total of admissions, 22·95 per cent. of the total number under treatment in the decade, and they averaged 7·56 per cent. per annum of the average number resident.

The deaths were 36·96 per cent. of the total admissions, 27·81 per cent. of the total number under treatment in the period, and they averaged annually 9·28 per cent. of the average number resident.

Throwing out the cases "transferred from other asylums," and those "re-admitted," the percentage of the remaining portion of the admissions, which may be taken roughly as "new cases," to the total admissions, during the six years 1869–74, has been 78·21.

It is an important and weighty fact that the percentages of recoveries obtained in the ten years, 1865–74, which formed the subject of the inquiry, do not show any very notable advance on those reached in the years 1845–54, twenty years earlier, while the deaths are relatively more numerous now than then. The higher death-rate may be in some measure due to the increased proportion of elderly paupers placed in asylums; but making liberal allowance for this cause of mortality, the rise is not adequately explained. The facts stated with regard to the diet scale should, we think, be considered in this connection. The figures for the two periods, in the public asylums of Middlesex and Surrey, may be stated as follows:—

	Total number admitted.	Total number treated.	Average number resident.	Total number recovered.	Total number of deaths.	Cures to admissions. Per cent.
1865-74	13,517 ...	17,966 ..	5382 ...	4124 ...	4996 ...	30·51
1845-54	6053 ...	7441 ...	2040 ...	1624 ...	2009 ...	26·83

	Cures to cases treated. Per cent.	Cures to average numbers resident. Per cent.	Deaths to admissions. Per cent.	Deaths to total numbers treated. Per cent.	Deaths to average numbers resident. Per cent.
1865 74	22·95 ...	7·56 ...	36·96 ...	27·81 ...	9·28
1845-54	21·83 ...	6·99 ...	33·19 ...	27·00 ...	9·24

The inference is, we think, unfavourable to the class of cases sent to asylums, rather than to the repute of the system of treatment pursued. The policy of finding accommodation for "*all* the lunatics in the county" creates a miscellaneous crowd, of which comparatively only a small percentage can be considered susceptible of cure or radical improvement.

The lessons of the inquiry point to an entire reconsideration of the measures adopted by authority to stem the torrent of this national scourge. The subject is one of deep and

pressing interest to the community of ratepayers, and it claims the special attention of the medical profession.

We have the satisfaction of acknowledging the courtesy with which the commission has been uniformly received, and the pains taken to place voluminous data at our disposal. Upon an exhaustive examination of the materials so supplied, together with much information collected from other sources, the conclusions embodied in this statement rest.

March 31*st*, 1877.

RETROSPECT.

STATISTICS OF ASYLUM POPULATION IN COUNTY AND BOROUGH ASYLUMS OF MIDDLESEX, SURREY, AND THE CITY OF LONDON, AS A WHOLE.

(Relating to the Ten Years covered by "The Lancet" Inquiry.)

Year.	Cases Admitted. Of all classes. Males.	Femls.	Total.	Recent. Deemed curable on admission.	Chronic or Recurrent. Transferred from other asylums.	Relapsed cases re-admitted.	Cases Resident. Total number under treatment.	Average number resident.	Average number employed.	Cases Discharged. On Recovery. Males.	Femls.	Total.	Recoveries occurring after residence in the asylum. Six months, or less.	Between six and twelve months.	Between one and two years.	Between two and three years.
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.
1865	498	530	1028	271	...	74	5477	4566	2046	125	155	280	139	76	37	14
1866	539	493	1032	207	...	63	5665	4802	2293	118	147	265	128	66	41	12
1867	628	671	1299	329	...	75	6185	5099	2467	112	158	270	129	77	41	9
1868	581	659	1240	342	...	66	6485	5387	2578	147	196	343	190	91	42	14
1869	600	504	1104	320	98	60	6540	5501	2552	166	173	339	165	103	49	16
1870	680	666	1346	488	166	101	6893	5641	2592	195	210	405	199	114	49	20
1871	1029	1140	2169	546	519	215	7719	5551	2601	234	288	522	266	176	42	15
1872	652	629	1281	546	138	115	7001	5717	2623	253	280	533	262	151	77	14
1873	714	782	1496	457	156	112	7224	5749	2476	218	265	483	253	125	53	30
1874	800	722	1522	683	126	137	7267	5804	2864	335	349	684	384	177	79	14
Gross number or proportion.	6721	6796	13,517	4189	...	1018	17,966	...	...	1903	2221	4124	2115	1156	510	158
Average number or proportion.	672·1	679·6	1351·7	418·9	...	101·8	6646	5382	2509	190·3	222·1	412·4	211·5	115·6	51·0	15·8
Abstract of the above particulars for the five years 1865 to 1869 inclusive.																
Gross number or proportion.	2846	2857	5703	1469	...	338	10,152	...	...	668	829	1497	751	413	210	65
Average number or proportion.	569·2	571·4	1140·6	293·8	...	67·6	6070	5071	2387	133·6	165·8	299·4	150·2	82·6	42·0	13·0
Abstract of the above particulars for the five years 1870 to 1874 inclusive.																
Gross number or proportion.	3875	3939	7814	2720	1105	680	13,361	...	...	1235	1392	2627	1364	743	300	93
Average number or proportion.	775·0	787·8	1562·8	544·0	221·0	136·0	7221	5692	2631	247·0	278·4	525·4	272·8	148·6	60·0	18·6

Year.	Discharged or removed. Relieved or Not improved.	By Death. Males.	Femls.	Total.	Deaths occurring after residence in the asylum. Six months, or less.	Between six and twelve months.	Between one and two years.	Between two and three years.	Assigned Cause. General Paralysis.	Epilepsy.	Pulmonary Phthisis.	Suicide or Accident.	Cases Remaining on December 31st. Total number.	Deemed curable.	Proportion per cent. of cases Deemed curable on Total number remaining.	Proportion per cent. of cases Deemed curable in C. & B. asylums generally.
	XVII.	XVIII.	XIX.	XX.	XXI.	XXII.	XXIII.	XXIV.	XXV.	XXVI.	XXVII.	XXVIII.	XXIX.	XXX.	XXXI.	XXXII.
1865	98	261	205	466	143	45	71	36	132	28	71	2	4633	222	4·79	**9·87**
1866	89	234	191	425	121	53	53	31	124	29	71	6	4886	164	3·36	**9·37**
1867	241	210	219	429	121	52	60	32	99	34	72	5	5245	223	4·25	**8·66**
1868	286	215	205	420	124	62	70	27	106	23	70	4	5436	228	4·19	**9·23**
1869	132	284	238	522	156	53	84	29	119	44	69	5	5547	209	3·77	**7·68**
1870	393	300	245	545	146	43	78	64	135	43	97	5	5550	288	5·19	**8·90**
1871	883	333	261	594	211	71	76	36	153	39	78	6	5720	301	5·26	**8·89**
1872	269	256	215	471	133	79	85	36	125	36	71	11	5728	326	5·69	**8·13**
1873	442	314	240	554	155	65	83	50	157	29	81	6	5745	276	4·80	**7·31**
1874	232	329	241	570	193	72	73	51	146	34	76	1	5781	288	4·98	**7·47**
Gross number or proportion.	3065	2736	2260	4996	1503	595	733	392	1296	339	756	51	...	...	...	...
Average number or proportion.	306·5	273·6	226·0	499·6	150·3	59·5	73·3	39·2	129·6	33·9	75·6	5·1	5427	253	4·63	**8·55**
Abstract of the above particulars for the five years 1865 to 1869 inclusive.																
Gross number or proportion.	846	1204	1058	2262	665	265	338	155	580	158	353	22	...	...	...	...
Average number or proportion.	169·2	240·8	211·6	452·4	133·0	53·0	67·6	31·0	116·0	31·6	70·6	4·4	5149	209	4·07	**8·96**
Abstract of the above particulars for the five years 1870 to 1874 inclusive.																
Gross number or proportion.	2219	1532	1202	2734	838	330	395	237	716	181	403	29	...	...	...	...
Average number or proportion.	443·8	306·4	240·4	546·8	167·6	66·0	79·0	47·4	143·2	36·2	80·6	5·8	5705	296	5·18	**8·14**

COMPARATIVE TABLE OF FACTS, COUNTY AND BOROUGH ASYLUMS (MIDDLESEX, SURREY, AND THE CITY OF LONDON) AS A WHOLE.

Year.	ADMISSIONS. SEX. Proportion per cent. of the Sexes in Middlesex and Surrey asylums.	ADMISSIONS. SEX. Proportion per cent. of the Sexes in County & Boro' asylums generally.	ADMISSIONS. AGE. Average age at admission.	RECOVERIES. SEX. Proportion per cent. of the Sexes in Middlesex and Surrey asylums.	RECOVERIES. SEX. Proportion per cent. of the Sexes in County & Boro' asylums generally.	RECOVERIES. AGE. Average age at recovery.	DEATHS. SEX. Proportion per cent. of the Sexes in Middlesex and Surrey asylums.	DEATHS. SEX. Proportion per cent. of the Sexes in County & Boro' asylums generally.	DEATHS. AGE. Average age at death.	Proportion per cent. of Recoveries on cases Deemed curable. (a)
	Males.	Females.	Males.	Females.			Males.	Females.	Males.	Females.		
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.
1865	48·44	51·56	49·72	50·28	38·3	44·64	55·36	43·75	56·25	36·9	56·01	43·99	56·18	43·82	48·2	55·78
1866	52·23	47·77	49·53	50·47	40·1	44·33	55·47	40·65	59·35	35·4	55·06	44·94	56·57	43·43	47·0	61·77
1867	48·34	51·66	49·50	50·50	40·6	41·48	58·52	41·83	58·17	35·4	48·95	51·05	55·52	44·48	48·2	54·77
1868	46·85	53·15	48·60	51·40	40·1	42·86	57·14	43·75	56·25	35·8	51·19	48·81	53·97	46·03	48·9	60·71
1869	54·35	45·65	50·20	49·80	39·3	48·97	51·03	43·81	56·19	34·3	54·41	45·59	54·91	45·09	48·9	61·86
1870	50·52	49·48	48·85	51·15	40·4	48·15	51·85	44·51	55·49	37·3	55·05	44·95	55·27	44·73	49·4	58·11
1871	47·44	52·56	50·12	49·88	38·7	44·83	55·17	44·29	55·80	37·6	56·06	43·94	56·13	43·87	50·6	62·59
1872	50·90	49·10	48·20	51·80	40·8	47·41	52·53	43·85	56·15	37·0	54·36	45·64	56·55	43·05	47·8	62·80
1873	47·73	52·27	49·42	50·58	40·5	45·13	54·87	43·49	56·51	37·4	56·68	43·32	56·86	43·14	48·8	61·69
1874	52·56	47·44	50·26	49·74	40·5	48·98	51·02	44·12	55·88	37·4	57·72	42·28	56·31	43·69	49·6	71·32
Gross number or pro portion.	49·72	50·28	49·45	50·55	...	46·24	53·86	43·49	56·51	...	54·76	45·24	55·89	44·11	...	...
Average number or pro portion.	49·94	50·06	49·44	50·56	39·9	45·70	54·30	43·40	56·60	36·5	54·55	45·45	55·87	44·13	48·7	61·15
Abstract of the above particulars for the five years 1865 to 1869 inclusive.																
Gross number or pro portion.	49·50	50·50	49·51	50·49	...	44·60	55·38	42·81	57·19	...	53·23	46·77	55·40	44·60	...	...
Average number or pro portion.	50·04	49·96	49·51	50·49	39·7	44·50	55·50	42·76	57·24	35·6	53·12	46·88	55·43	44·57	48·2	58·98
Abstract of the above particulars for the five years 1870 to 1874 inclusive.																
Gross number or pro portion.	49·59	50·41	49·41	50·59	...	47·01	52·99	44·03	55·97	...	56·04	43·96	56·30	43·70	...	...
Average number or pro portion.	49·94	50·06	49·37	50·63	40·2	45·70	54·30	44·03	55·97	37·3	54·55	45·45	56·30	43·70	49·2	63·33

(a) This percentage is upon cases "Deemed curable" brought over from previous year [Statistics of Asylum Population, col. xxx i. and "Cases deemed curable on admission" [col. iv., *third*], *pinced here because unprovided.*

COMPARATIVE TABLE OF RESULTS, COUNTY AND BOROUGH ASYLUMS (MIDDLESEX, SURREY, AND THE CITY OF LONDON), AS A WHOLE.

Year.	RECOVERIES. Proportion per cent. on cases admitted.	RECOVERIES. Proportion per cent. on cases admitted in County and Boro' asylums generally.	RECOVERIES. Proportion per cent. on Total number under treatment in each year.	RECOVERIES. Proportion per cent. on Average number resident in each year.	RECOVERIES. Proportion per cent. on Total number resident in each year in County and Boro' asylums generally.	RELAPSES. Proportion per cent. on New Cases (a) admitted and re-admitted.	RELAPSES. Proportion per cent. on New Cases (a) admitted in current year.	RELAPSES. Proportion per cent. on Recoveries.	RELAPSES. Proportion per cent. of Relapsed cases re-admitted on Recoveries in Col. 8 in asylums generally.	DEATHS. Proportion per cent. on cases admitted.	DEATHS. Proportion per cent. on cases admitted in County and Boro' asylums generally.	DEATHS. Proportion per cent. on Total number under treatment.	DEATHS. Proportion per cent. on Average number resident in each year.	DEATHS. Proportion per cent. on Total number resident in each year in County and Boro' asylums generally.	Proportion per cent. on Average number resident in each year.
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.
1865	27·94	33·88	5·11	8·59	6·13	11·03	...	...	36·47	...	45·33	33·70	8·51	8·46	10·21	10·97
1866	25·68	35·71	4·68	8·06	5·58	10·23	...	...	23·77	...	42·18	37·57	7·39	8·48	8·85	10·76
1867	20·79	36·20	4·37	8·38	5·30	10·65	...	...	27·78	...	33·03	36·22	6·94	8·38	8·41	10·66
1868	27·66	36·10	5·29	8·47	6·37	10·76	...	...	19·24	...	33·87	34·07	6·48	7·99	7·80	10·15
1869	30·72	35·72	5·28	8·29	6·16	10·56	28·88	32·14	27·70	38·25	47·26	37·79	7·98	8·77	9·49	11·17
1870	30·09	36·37	5·88	8·54	7·16	10·93	31·44	35·63	24·94	38·15	40·49	36·11	7·31	8·43	9·66	10·82
1871	24·07	33·78	6·76	8·53	9·40	11·29	30·30	34·49	41·19	37·73	27·39	32·06	7·70	8·10	10·79	10·71
1872	41·62	38·35	7·61	8·81	9·39	11·18	40·21	36·59	21·58	33·05	36·77	32·33	6·73	7·54	8·24	9·57
1873	32·29	33·96	6·69	8·92	8·40	10·33	31·08	33·39	23·19	38·68	37·03	35·19	7·67	8·31	9·64	10·70
1874	44·94	37·90	9·41	8·95	11·78	11·46	44·56	37·31	20·93	33·67	37·45	35·22	7·84	8·34	9·82	10·68
Gross number or pro portion.	30·51	35·80	22·95	28·30	...	...	42·18	44·59	24·68	35·99	36·96	34·59	27·81	27·66	...	...
Average number or pro portion.	30·51	35·80	6·10	8·46	7·56	10·84	34·40	34·93	24·59	36·10	37·08	35·09	7·52	8·29	9·28	10·62
Abstract of the above particulars for the five years 1865 to 1869 inclusive.																
Gross number or pro portion.	26·23	35·53	14·75	22·34	...	...	...	...	20·58	...	39·66	35·86	22·28	22·55	...	...
Average number or pro portion.	26·42	35·52	4·93	8·34	5·90	10·65	...	...	22·98	...	40·14	35·87	7·48	8·42	8·95	10·74
Abstract of the above particulars for the five years 1870 to 1874 inclusive.																
Gross number or pro portion.	33·62	36·03	19·66	22·47	...	...	42·11	45·04	23·89	35·59	34·99	34·28	20·46	21·37	...	...
Average number or pro portion.	34·60	36·07	7·07	8·57	9·22	11·03	35·50	35·48	26·19	35·66	35·83	34·30	7·57	8·15	9·61	10·50

(a) "New Cases" are "Cases admitted" during the year, *less* cases "Transferred from other asylums" and "Relapsed cases re-admitted," both which have been deducted [Statistics of Asylum Population, col. iii., less cols. v. and vi.].

ANALYSIS OF RESULTS

In County and Borough Asylums for Middlesex, Surrey, and the City of London, during the Ten Years of "The Lancet" Inquiry, 1865–74.

The preceding four pages epitomize the figures set out in the tables appended to the reports on asylums at Brookwood, Hanwell, Colney Hatch, Wandsworth, and Stone, for the ten years, 1865–74. It is impossible to localize the cases treated in the hospitals, and we cannot fairly regard the inmates of asylums for imbeciles as lunatics. The retrospect is therefore limited, in this branch of the inquiry, to the county and borough asylums of Middlesex, Surrey, and the city of London. It will be convenient to deal with the chief topics of interest in order.

I. CASES ADMITTED.

The total number of cases admitted into the five asylums during the years 1865–74 has been 13,517; the average annual number being 1351·7. The smallest aggregate in any one of the ten years was 1028, in 1865; the greatest, 2169, in 1871. This sudden increase in the rate of admissions, 61·14 per cent. on the number admitted in the previous year (1870), 1346, 69·32 per cent. above the level of the year following (1872), 1281, was possibly in some degree anticipatory of the measure which allowed a grant of four shillings per head in aid of the maintenance of lunatics in asylums. The number sent to licensed houses in the same year (1871), however, shows a decline. Throwing the exceptional return, for 1871, out of account, the highest annual number of cases admitted was 1522 in the year 1874, the last of the series. This exhibits an increase upon the total number of admissions in

1865 equal to 48·05 per cent., and it is 12·60 per cent. above the mean of the ten years, 1351·7, which is itself an increase of 31·49 per cent. upon the number admitted in 1865. It must therefore be concluded that the number of lunatics sent to public asylums in Middlesex, Surrey, and the city of London has considerably increased during the ten years under review. Making full allowance for the working of the grant towards maintenance in asylums, and checking the figures by the numbers admitted into the metropolitan licensed houses, which increased from 735 in 1865, to 903 in 1874, or 22·86 per cent., this is a significant circumstance.

I have elsewhere pointed out that no inference as to the general progress of lunacy can be drawn from the admissions into asylums. The first Note in the concluding section of this work deals with that subject at length; but I may here say that in examining the results gleaned in this inquiry, it is important to guard against the errors which must arise from any attempt to generalize. It should be borne in mind that we are reviewing the county and borough asylums for Middlesex, Surrey, and the city of London only, and at the moment have no concern beyond the limit indicated, except as regards the proportional standards derived from the returns of county and borough asylums generally, which are introduced solely for the elucidation of details by comparison.

(*a.*) *Proportion of the Sexes.*

The proportions of the sexes in the gross number of patients admitted during the ten years were—males, 49·72; females, 50·28; showing only 0·56 per cent. more females than males. The difference is fractionally less than that presented by the returns of county and borough asylums generally, in which the proportions were—males, 49·45; females, 50·55; an excess of 1·10 per cent. in female patients. The average annual proportions in the five asylums have been—males, 49·94; females, 50·06; showing 0·12 per cent. more of females than of males; while the same figures for county and borough asylums generally have been—males, 49·44; females, 50·56; or 1·12 per cent. of females above males. The fluctuations of proportion in the sexes during the ten years are not im-

portant, except as indicating that in certain years the workhouses have been cleared of the old women; for example, 1871, when the proportions were suddenly reversed, becoming —males, 47·44; females, 52·56. The same thing happened in 1867, and again in 1873, as will be seen by reference to columns i. and ii. in page 52. A glance at columns iii. and iv. will show the change was not general in 1871, but exactly opposed to the position of affairs in England and Wales at large, where the total proportions were—males, 50·12; females, 49·88.

(*b.*) *Age.*

The mean age of cases admitted in the years 1865–74 has been 39·9. The average would be fractionally higher but for the circumstance that in 1865 and 1871 a considerable number of idiots were removed to the asylums. I should be inclined to place the average age of the ten years at 39·50, and infer from the circumstance that the mean is greater for the years 1870–4 than 1865–9, as shown by the abstracts in column v., page 52, that there is a tendency to increase. Probably this is due to the evident disposition to remove the aged poor from workhouses to asylums on the plea of dementia.

(*c.*) *Cases Deemed Curable on Admission.*

It would be interesting and important to lay stress on the proportion of cases "deemed curable on admission," if an accurate return could be obtained. I have explained (at page 72, vol. i.) my reasons for attaching little value to the best figures I found it possible to employ as the basis for a calculation of percentages. The fact that they are not trustworthy for the purpose with which I collected them does not, however, invalidate their use as an indication of the class of cases admitted; and in this light we may now regard them. Of the 13,517 cases admitted to the five asylums during the years 1865–74, 4189 were "deemed curable on admission;" that is, 30·99 per cent. It is not possible to ascertain how many of these were *new* or recent cases, but an approximate estimate may be made for the last half of the decade, namely, the years 1870–4. It will be seen by the second abstract (col. iv., page 50) that 2720 cases were "deemed curable on

admission" during the last five years, against a total number admitted of 7814, that is, 34·81 per cent. Deducting 1105 cases "transferred from other asylums" (abstract, col. v.), and 680 "relapsed cases re-admitted" (abstract, col. vi.), = 1785, from the gross number 7814, there remain 6029 which should be "new cases." The circumstance that only 2720, or 45·12 per cent. of this number, 6029, were "deemed curable on admission"—that number being reached as explained in the footnote to page 300, vol. i.—is remarkable. The obvious inference bears out the opinion I have formed on other grounds, namely, that the real use of these asylums in hospital work is neglected, and their remedial power wasted on the care of the incurable. Something like 3309, or 55 per cent. of the cases admitted, without any previous asylum history, were in fact *old* cases, either from workhouses, or the custody of friends.

(*d.*) *Cases Transferred.*

The returns do not, as we have seen, admit of our studying the proportion of transfers in the first five years, but we can do this for the quinquennial period, 1870–4. The total number of cases admitted in the last five years, as shown by the abstract (col. iii., page 50), was 7814. The transfers were 1105 (col. v.), or 14·14 per cent. of the gross number. This proportion nearly represents the old *asylum cases* admitted, as the opening of the new establishments at Stone and Brookwood occurred before that portion of the period to which the figures relate. I do not, however, think any great significance attaches to the proportion of transfers in a limited district, except as a check on the general computation of cures upon admissions, from which they must of course be eliminated, if it be desired to estimate the work done upon a reasonable basis.

(*e.*) *Relapsed Cases Re-admitted.*

These are given for the full period of ten years. The gross number was 1018 (col. vi., page 50), which equals 7·53 per cent. of the total admissions, 13,517. Looking to the two abstracts, we find the number of relapses is 338 for the first five years, against a total of 5703 cases admitted, or 5·93 per cent.; and 680 against 7814, or 8·70 per cent., for the last

quinquennial period—the average annual number during the first five years being 67·6; that during the latter five, 136·0. Whether it would be fair to conclude that the pressure on accommodation led to the discharge of cases prematurely, and their consequent relapse and re-admission, I will not stop to inquire. Meanwhile, we shall find, on turning to column ix., page 53, the gross proportion of "Relapsed cases re-admitted on recoveries" was 24·68 for the whole period, while it was 22·58 and 25·89 for the first and last five years respectively. This certainly gives some ground for the apprehension I have suggested. The average annual proportion per cent. of relapses on recoveries rose from 22·98 to 26·19 per cent. in the two periods; and although both proportions are most creditably below the average for the county and borough asylums generally (see col. x., page 53), the retrogression furnishes subject for thought.

2. CASES RESIDENT.

The population of an asylum, although subject to ceaseless change as regards its elements, is a tolerably constant number in its relation to the accommodation available. Whether the aggregate community of the insane is progressive beyond its natural increment as an integer of the population as a whole, is a question foreign to the present inquiry. I am most anxious to guard against misconception on this point. We cannot even determine whether the total of insanity is increasing in the counties and city under review, for the reason assigned in the first Note, to which I would again refer the reader.

(*a*). *Total Number under Treatment.*

The cases in residence at the outset, plus those admitted in the course, of any period will be the "Total number under treatment" during the term defined. Column vii., page 50, shows the total number for each year, for the decade, and for the two quinquennial periods which compose it. The gross of the years 1865–74 was 17,966; the average annual number, 6646. During the first five years, 1865–9, the total number under treatment was 10,152; the average, 6070. The abstract for the latter period, 1870–4, shows a total of 13,361, with an average of 7221. Practically, these facts have no bearing

except upon the question of accommodation existing and occupied. They are, however, important as supplying bases for computations of death-rate and cure.

(*b.*) *Average Number Resident.*

The numbers given in column viii., page 50, are—For the decade, 5382; for the two periods of five years respectively, 5071 and 5692. The relation which these numbers bear to the "Total number under treatment" in the three periods respectively is important as indicating the class of cases comprised, and throwing some light on the average duration of residence, or what Dr. Thurman, in his *Statistics of Insanity*, calls "subjective time." It will be seen, on comparing the figures in columns vii. and viii., page 50, that regarding the ten years as a whole, 17,966 produced an average population of 5382. In the first five years 10,152 produced an average of 5071 residents; while in the latter, 13,361 gave 5692. The comparative percentages are as follows:—29·96 for the whole decade; 49·95 for the five years, 1865–9; 42·60 for the years 1870-4. The difference of the two percentages, for ten and five years respectively, is explained by the fact that the longer term covers the duration of 16·32 per cent. of the total number of cases under treatment; that is the excess of 46·28, the mean of the two periods of five years, over 29·96, the rate for the whole decade. This is a theoretical proposition, but sufficiently accurate to illustrate the argument. It is the corollary of the fact that with an average percentage of 6·10 recoveries annually, 22·95 per cent. were cured in ten years (see col. iii., page 53, explained at page 74, vol. i.).

(*c.*) *Average Number Employed.*

The value of this record is twofold. It helps to throw light on the class of patients under treatment, as it may be fairly assumed that working patients are neither very turbulent nor very old. On the other hand, the relative proportion occupied affords some indication of the efficiency of the management, and the extent to which wise measures prevail in an administration. It is, however, necessary to bear in mind that very much the same result may be obtained with materials of totally different character. The

"employed" may be either convalescent or chronic lunatics or they may be able-bodied paupers, whose real place is in the workhouse. My tables show that, taking the ten years throughout, an average resident population of 5382 yielded 2509 workers, or 46·62 per cent. In the first five years, 2387 were employed out of 5071, or 47·07 per cent.; in the last five years, 2631 out of 5692, or 46·22 per cent.

(*d.*) *Length of Residence.*

The following table summarizes the recoveries and deaths during the decade under the several periods set out in columns xiii.–xvi. and xxi.–xxiv., pp. 50–1, and those falling beyond the limit of three years. The number of cases removed "Relieved or not improved," probably to be transferred to other asylums, are not counted, as it is impossible to determine at what periods of residence they were discharged.

	NUMBER DISCHARGED CURED OR DEAD.						PER CENT. TO TOTAL.				
PERIODS.	Under six months.	Six to twelve months.	One year to two years.	Two years to three years.	Above three years.	Total.	Under six months.	Six to twelve months.	One year to two years.	Two years to three years.	Above three years.
Ten years, 1865–74	3618	1751	1243	550	1958	9120	39·67	19·20	13·63	6·03	21·47
Five years, 1865–9	1416	678	548	220	897	3759	37·67	18·04	14·58	5·85	23·86
Five years, 1870–4	2202	1073	695	330	1061	5361	41·08	20·01	12·96	6·16	19·79

It will be seen that the numbers discharged cured or dead during the several periods were very unequal. Cases ending within six months of admission were 20·47 per cent. more numerous than those terminating in between six and twelve months; the discharges falling beween six and twelve months after admission were 5·57 per cent. in excess of those in the second year of residence; and those in the second year, 7·60 per cent. more than those in the third. The cases discharged after the third year were 1·81 per cent. more in number than those discharged after a residence of between one and three years.

3.—CASES DISCHARGED.

Cases recover; patients are discharged relieved or not improved, they are transferred to other asylums; or they die.

These three terminations of residence are comprehended under the description "Cases discharged."

(*a.*) *On Recovery.*

It is difficult to say what "recovery" means. In practice, probably, no two medical superintendents would be found to agree as to what constitutes a *cure*. Some deny the possibility of perfect recovery; others appear to accept any improvement—even the change in condition which signalizes the transition from acute disease to incipient dementia—as "recovery." The only check on this diversity of opinion would seem to be the proportion per cent. of relapses on recoveries; but even this is uncertain as a test, because it commonly happens that patients prematurely discharged are removed to a distance, and, when a relapse occurs, do not return to the asylum in which they previously resided. Whether this occurs more frequently among pauper or private patients, I am not in a position to judge. It is, however, manifest that "recovery" must be understood in a limited sense, and regarded in connection with other indications of success in treatment, when attempting to estimate the results obtained at any particular institution.

Proportion of the Sexes in Recoveries.—The males recovering in ten years have numbered 46·14 per cent.; the females, 53·86. The same proportions for county and borough asylums generally were 43·49 males and 56·51 females. The fluctuations are not great. The average annual proportions at these five asylums may be taken as 45·70 for males, and 54·30 for the females. The excess on the side of the females is 7·72 per cent. in the gross, and 8·60 per cent. annual average.

Average Age of Patients Recovering.—The mean age has been 36·4 for the decade, 35·6 for the first five years, and 37·3 for the last. It will be noted that the average age at recovery is, speaking broadly, about two years lower than that of patients admitted. This is important. The fact tells against the chances of cure—when computed for numbers and recognizing the element of time as an integer in the series of probabilities.

Percentage of Recoveries on Cases Admitted.—This is the most obvious computation, and affords a ready method of appraising the results of treatment. The proposal to count recoveries upon discharges, instead of admissions, does not commend itself to my own judgment; but it will be easy for any one preferring that method to estimate either recoveries or deaths upon the aggregate of cases discharged "on recovery," "relieved or not improved," and "by death," as set out in the tables. For example, the total would be got by adding 4124 (col. xii.), 3064 (col. xvii.), and 4996 (col. xx) = 12,184, gross discharges of the ten years. The recoveries, 4124, upon this would equal 33·85 per cent. The average may be computed from the yearly rates, obtained in the same way. Meanwhile the proportion of recoveries on admissions—4124 (col. xii.) upon 13,517 (col. iii.)—gives 30·51 (col. i., page 53) per cent. on the total of the decade; which exactly corresponds with the average of the annual rates of the period. The gross and average percentages appearing in the abstracts of column i., page 53, are for the first five years 26·25 and 26·42 per cent.; for the second five years, 33·64 and 34·60 per cent. On reference to column ii., page 53, it will be seen that the like figures for county and borough asylums generally are considerably higher. I think this shortcoming must in large measure be due to the fact that, within the area of the inquiry, the decade witnessed the opening of two new asylums, which were peculiarly situated as regards the class of cases they received. An asylum does not attain its normal level until five and twenty, or thirty, years after the date of opening, and in the earlier stages of its history it is exposed to considerable fluctuations, the precise nature of which it is impossible to predict, and whose cause it is sometimes difficult to discover. The proportions of recoveries in the five asylums we are considering have fallen below the general proportions about 5·29 per cent. both on the gross and on the average of the ten years; 9·28 per cent. on the gross and 9·10 per cent. on the average of the first five years, and 2·39 and 1·47 per cent. on the gross and average, respectively, of the last half of the decade. Following this discrepancy into detail, it will appear, on reference to the similar table for each of the five asylums, that Brookwood shows a deficiency of

11·59* per cent. on the gross, and of 4·36 per cent. on the average of the ten years; Hanwell, of 5·06 per cent. on the gross, and 3·93 per cent. on the average; Colney Hatch, of 2·65 per cent. gross, and 2·33 per cent. average; Wandsworth, of 2·71 per cent. gross, and 2·68 per cent. average; and the City of London of 18·25* per cent. gross, and 8·60 per cent. average, respectively. The net result of these differences is expressed in the proportional figures appearing in the summary table we are now discussing, which treats the asylum population as a whole.

Proportion per cent. of Recoveries on Total Number under Treatment.—This, it appears to me, is the most useful and sound calculation: Out of a given number of cases submitted to treatment, how many are cured? Here, however, the element of time comes prominently into play. I have more than once adverted to the curious circumstance that, while a given number of cases only are found to recover annually, a proportionally larger number will recover in a longer period. It amounts to this—begin the term examined when you will and close it when you please, the longest period gives the largest number of case-endings either by recovery or death. If you take a year, 6 or 7 per cent. will be discharged cured; if five years, nearly 15 per cent.; if ten years, probably 20 per cent. The reason is obvious—a large proportion of cases recover in a short period; but there are always so many slow, but finally, curable cases that, if the time is long enough to comprehend the average duration of a case of lunacy, complete cases which have run their course within the period under review will be added to the proportional sum of the annual recoveries. In this way a percentage is built up far in excess of the average yearly rate. From the table, page 53, col. iii., it will be seen the proportion per cent. of recoveries upon the number under treatment has averaged during ten years, for the five asylums we are considering, 6·10 per cent. per annum, while the percentage of total cures upon the

* The comparatively recent date at which the Brookwood and City of London Asylums were opened renders any calculation based upon the gross numbers incapable of being compared with a similar computation for the county and borough asylums generally; in working out the average annual rates, however, a correction has been made. (See note to Statistical Tables, p. 257, vol. i.)

gross number under treatment during the decade has been 22·95. The abstracts for the two periods of five years, in the same column, show 4·93 per cent. annually for the first period, and 14·75 per cent. for the whole five years. The like figures for the last five years are 7·27 and 19·66. Column iv., representing county and borough asylums generally, gives 8·46 per cent. per annum, and 28·30 per cent. for the ten years; 8·34 per cent. annually, and 22·34 per cent. gross for the first five; and 8·57 and 22·47 per cent. respectively for the average and the gross of the last five years. It will therefore appear that there has been a slight increase in the percentage of cures during the last quinquennial period generally; and the five asylums in our list have doubtless participated in the rise, although something of the improvement observed must be ascribed to the mobility of the population, which, if it aggravates the death-rate, also raises the proportion of recoveries.

Proportion per cent. of Recoveries upon Average Numbers Resident.—This is a percentage not usually taken, but I think it is worth calculating, if only as a set-off to the usual death-rate. Moreover, it is necessary, in regard to a matter of so much interest as the result of lunacy practice, to apply the largest number of checks and counter-checks to every inference, and I believe the judgment formed will be sound and practical in proportion to the pains taken to counter-check the chances of error. Acting on this principle, I have arranged these tables to afford facilities for the application of tests of every kind; and if the reader is interested—which I must assume is the case, or he would not be wading through these dry details—he will perceive the advantage of examining the proportion of recoveries from all convenient standpoints. The figures in columns v. and vi., taken together, will show that the results attained in these asylums are not up to the average for the country as a whole. The annual percentage of cures upon average numbers resident in the county and borough asylums generally has been 10·84 per cent. during the ten years 1865–74, or 10·65 per cent. for 1865–9 and 11·03 for 1870–74. The same percentages for the five asylums visited are 7·56, 5·90, and 9·22. The improvement

apparent on the face of the previous calculations of recoveries, upon "admissions" and "average number resident," appears here also: 9·22 is 3·32 per cent. better than 5·90. Meanwhile there is an increase of 0·38 per cent.,—11·03 against 10·65—in the figures printed in column vi., page 53. We must assume that the asylums under notice have shared in the general advance. The bulk of the 3·32 per cent. increase of this last upon the first half of the decade at the five asylums may, however, be attributed to the causes previously mentioned as helping to produce improvement, including the more efficient working of the new establishments after the difficulties of starting were overcome.

Proportion per cent. of Recoveries upon New Cases, etc.—A foot-note to columns vii. and viii. in all the tables explains that by "New cases" I mean "Cases admitted," less those "Transferred from other asylums" and the "Relapsed cases re-admitted," which have been deducted. I have already explained that this is only an approximate definition, because many cases not excluded may in fact be old; but I think the calculation worth making. The average annual proportion per cent of cures during the last five years upon new cases and cases still "deemed curable" left over from the previous year, is 35·50 per cent. for the five asylums, and 35·48 per cent. for county and borough asylums generally.

Length of Residence in Cases Discharged Recovered.—This is a matter of great interest. Of the 4124 which recovered in the ten years 1865–74, 2115 were under treatment less than six months; 1156 between six and twelve months; 510 from one to two years; 158 between two and three years. Together these make 3939, leaving 185 who recovered after three years. The several proportions per cent. of the total are as follow:—Within six months, 51·29 per cent.; between six and twelve months, 28·03 per cent.; between one and two years, 12·37 per cent.; between two and three years, 3·83 per cent.; and over three years, 4·48 per cent. It would be impossible to work out a trustworthy general proportion from the small number of 4124 recoveries, but the reader will find, at page 98, a deduction made from the larger field offered in the analysis of results covering the entire history of the asylums visited.

(*b.*) "*Relieved*" *or* "*Not Improved.*"

No practical value attaches to this description of cases, except for the purpose of elimination. During the ten years 3064 discharged were thus reported; but doubtless many re-entered the insane population, as relapsed cases or transfers, at asylums where they were unknown. The reports of legal advisers acting for asylum committees show that it is often long before the settlement of a pauper patient can be discovered, and in many cases even his recent history is not easily traced.

(*c.*) *Cases Discharged by Death.*

The total number of cases dying under treatment in the ten years has been 4996; the average annual number, being 452·4 for the first five years, with a total of 2262; and 546·8, with a total of 2734, in the latter half of the decade. The increase of deaths in the last five years, as compared with the previous quinquennial period, must be regarded as complementary to the increase of recoveries, and the two facts taken together suggest the explanation I have indicated—namely, greater mobility of population, involving augmented chances of recovery but with higher risks. To this may be added the inference which a slightly advanced average age at death seems to justify, as to the general unfitness of the cases admitted.

Proportion of the Sexes in Deaths.—The percentages have been—males, 54·76; females, 45·24, on the gross of the ten years; the average annual proportions, 54·55 males, 45·45 females. The percentage of the excess in the case of males is 9·52 on the gross number and 9·10 on the average.

Average Age of Patients Dying.—The average for the ten years is 48·7; for the first five years it was 48·2, and 49·2 for the last, showing a trifling advance probably explained by the increased proportion of elderly patients recently admitted.

Proportion per cent. of Deaths upon Admissions.—It is not customary to make this computation, but it affords a ready estimate of probabilities. The proportion for the five asylums was 36·96 per cent. upon the gross of the ten years, with an average annual death-rate of 37·98. It will be seen from the abstract for the years 1865–9, column xi., page 53, that the

average annual death-rate was as high as 40·14 per cent.; the gross proportion of deaths, 39·66. The rate fell in the last five years to 35·83 per cent. per annum, and 34·99 on the total number of the period. These last percentages do not materially differ from those shown in column xii. for county and borough asylums generally, namely, 34·30 annually and 34·28 on the total of admissions. It will be seen, on comparing columns ii. and xii., that the rates of recovery and death approximate closely; in other words, the chances of a happy or fatal issue are nearly equal, with a fractional advantage on the side of hope. In the asylums under review, however (cols. i. and xi.), the rate of mortality is higher than the rate of cure.

Proportion per cent. of Deaths on Total Number under Treatment.—This percentage follows the same rule of increase as the like proportion in the case of recoveries. The gross number of deaths in the five asylums during the ten years was equal to 27·81 per cent. of the total number under treatment, with an annual percentage of 7·52. This, it will be seen, makes the deaths proportionally more numerous than the recoveries. The abstracts for the two quinquennial periods do not present any great difference as regards the death-rate. There is, however, some improvement in the total proportional mortality during the last five years, as compared with the preceding five. The percentages shown in column xiv., for the county and borough asylums generally, are less satisfactory. While the average annual death-rate for the five asylums during the ten years under review has been 7·52, the general rate has been 8·29. This is a circumstance which may fairly be taken as a set-off to the relatively large proportion on the admissions. Of the total number under treatment, 27·66 per cent. have died during the ten years in asylums of the same class generally, while the deaths amounted to 27·81 per cent. in the five asylums, taking the gross; but the average annual rate has been lower in the small population we are studying than in the larger population of the county and borough asylums as a whole. It is therefore possible to believe that the excess of deaths on the gross number under treatment and on the admissions is accounted

for by the presence of a considerable number of old persons; and the increasing age at death bears out this conclusion, as we have seen.

Proportion per cent. of Deaths on Average Number Resident.—In respect to this percentage, as to the last, the five asylums show well. The average annual rate for the ten years is 9·28 per cent., against 10·62 in the county and borough asylums generally. The two abstracts are 8·95 and 9·61. This gives an increased death-rate for the last five years, but, as was remarked above, the greater age at death suggests that the rate has been raised by crowding the asylums with the aged and infirm.

Length of Residence of Patients Dying.—The numbers shown in columns xxi., xxii., xxiii., and xxiv., page 51, are 1503, or 30·08 per cent. of the total 4996, dying within six months; 595, or 11·91 per cent., between six and twelve months; 733, or 14·67 per cent. between one and two years; 392, or 7·85 per cent., between two and three years; and 1773, or 35·49 per cent., after three years. The proportional percentages differ from those observed in the recoveries, and it will be noticed the number dying in the first period (six months) is in greater excess of the number in the second (six to twelve months) than the number of recoveries in the first period is greater than that in the second period. (See page 65.)

"Assigned" Cause of Death.—General paralysis accounts for 1296 deaths, or 25·94 per cent. of the total number (4996); pulmonary phthisis for 756, or 15·13 per cent.; epilepsy for 339, or 6·78 per cent.; and suicide or accident for 51, or 1·02 per cent. It will be well to reserve remark until we have investigated the more extensive area of facts presented by the history of the five asylums from the outset. (See, also, the observations on this topic in Note "Statistics of Lunacy" at the end.)

4. CASES REMAINING.

The interest attaching to these, centres in two points—1. The proportion left to the number "admitted" and the "total number under treatment"; 2. The percentage of those remaining, which can be "deemed curable."

Proportion of Total Number remaining to the Admissions of the Period.—In the ten years 1865–74, 13,517 were admitted into the five asylums, and at the end 5781 patients remained, or 42·77 per cent. upon the admissions. The decade commenced with a population of 4449 left over from 1864. In the first five years, 1865–9, 5703 were admitted, and at the end of 1869 there were 5547 inmates, equal to 97·26 per cent. upon the admissions. In the last quinquennial period, 1870–4, 7814 cases were admitted, and on December 31st, 1874, 5781 patients remained, or 73·98 per cent upon the admissions. It must be understood this percentage is simply upon the *number* of admissions, and does not touch the question what proportion, of the particular patients admitted, remained. The individual cases are not followed; their history can only be traced in the discharges.

Proportion of Number remaining to the Total Number under Treatment.—In the ten years, 17,966 were under treatment, and 5781, or 32·18 per cent., remained in the asylums at the close. During the first half of the decade, 10,152 were treated, and at the close of 1869, 5547 remained, or 54·64 per cent. In the last five years, 1870–4, 13,361 were treated, and at the end of 1874, 5781, or 43·27 per cent., remained.

Proportion of Total Number remaining "Deemed Curable."—At the end of the ten years, 1865–74, 288, or 4·98 per cent. of the total number remaining (5781), were deemed curable. At the close of the first five years, 209, or 3·77 per cent. of 5547, remained curable. The average number of cases "deemed curable" at the close of the several years 1865–9 was 209; the proportion being 4·07 per cent. of 5149, the average number remaining at the end of each year: in the following quinquennial period, 1870–4, the proportion was 5·18 per cent.

STATISTICS OF THE YEAR 1875.

The long period over which this inquiry has unavoidably extended renders it desirable to bring the supplementary analyses up to a date more recent than 1874. I have therefore appended a table, completing the facts and computations for 1875.

The features of the year, from a statistical point of view, are not remarkable.

STATISTICS OF ASYLUM POPULATION IN INSTITUTIONS VISITED, FOR 1875.

NAMES OF INSTITUTIONS.	CASES ADMITTED. OF ALL CLASSES, DURING THE YEAR.						CASES RESIDENT.			CASES DISCHARGED. ON RECOVERY.			DISCHARGES OCCURRING AFTER RESIDENCE IN THE ASYLUM.				CASES REMAINING OR DECEASED DEC. 31ST, 1875.			
				CHRONIC OR RECURRENT.																
	Mls.	Fmls	Tl.	Discharged recoveries on admission.	Transferred from other Asylums.	Relapsed cases re-admitted.	Total number under treatment.	Average number resident.	Average number employed.	Mls.	Fmls	Tl.	Six miles, or less.	Between six and twelve miles.	Between one and two years.	Between two and three years.	Total number.	Deemed curable.	Proportion per cent. of cases Deemed curable on Total number remaining.	Proportion per cent. of cases Deemed curable in C. & B. asylums, Registered hospitals, or Metropolitan Licensed Houses generally.
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.	XVII.	XVIII.	XIX.	XX.
County and Borough Asylums :—																				
Brookwood	131	198	329	76	160	15	974	669	450*	44	35	79	56	14	3	—	799	98	3·50	7·17
Hanwell	205	150	364	132	35	22	2177	1823	1120	82	63	145	67	39	13	5	1822	84	4·61	7·17
Colney Hatch	351	339	690	253	43	66	2779	2083	774	109	133	242	131	77	25	2	2090	99	4·74	7·17
Wandsworth	188	317	505	198	133	70	1453	1030	468	77	104	182	141	28	7	1	1060	70	6·60	7·17
City of London	64	42	106	30	44	3	302	332	203	16	8	24	16	5	1	1	333	30	9·01	7·17
Metropolitan District Asylums :—																				
Caterham †	260	226	486	..	...	...	2351	1842	815	19	9	28	8	8	1	2	162 †	133	161	294
Leavesden	112	109	221	...	...	...	2014	1796	...	10	8	18	9	2	2	2	36	81	96	177
Registered Hospitals :—																				
Bethlem	91	140	231	229	20	30	480	265	138	48	75	123	64	44	13	—	71	13	9	22
St. Luke's	33	69	102	87	7	16	284	184	...	12	31	43	28	16	9	—	25	7	4	11
Metropolitan Licensed Houses :—																				
Camberwell	78	154	232	81	16	16	707	462	...	27	63	90	...	...	...	...	140	28	43	71
Bethnal House	62	121	183	63	4	17	579	392	...	26	40	66	...	...	...	...	97	15	21	36
Hoxton House	38	97	135	44	—	3	453	309	...	5	32	37	...	...	...	...	95	17	25	42
Peckham House	135	149	274	79	11	30	636	370	...	33	51	84	...	...	...	...	202	36	32	68
Grove Hall, Bow	83	—	83	27	—	2	520	446	...	29	—	29	...	...	...	...	13	41	—	41

* Approximate number.
† The Caterham Asylum report relates to the period between 1st October, 1874, and 30th September, 1875.

NAMES OF INSTITUTIONS.	DISCHARGED. NOT RECOVERED. BY DEATH.			DEATHS OCCURRING AFTER RESIDENCE IN THE ASYLUM.				ASSIGNED CAUSE.					CASES REMAINING OR DECEASED DEC. 31ST, 1875.			
	Relieved or Not improved.	Males.	Females.	Total.	Six months or less.	Between six and twelve months	Between one and two years.	Between two and three years.	General Paralysis.	Epilepsy.	Pulmonary Phthisis.	Suicide or Accident.	Total number.	Deemed curable.	Proportion per cent. of cases Deemed curable on Total number remaining.	Proportion per cent. of cases Deemed curable in C. & B. asylums, Registered hospitals, or Metropolitan Licensed Houses generally.
	XXI.	XXII.	XXIII.	XXIV.	XXV.	XXVI.	XXVII.	XXVIII.	XXIX.	XXX.	XXXI.	XXXII.				
Brookwood	25	44	27	71	21	8	8	10	14	7	5	--	799	98	3·50	7·17
Hanwell	35	101	74	175	44	13	24	12	32	3	27	—	1822	84	4·61	7·17
	216 *	136	95	231	82	43	32	11	56	25	24	1	2090	99	4·74	7·17
Wandsworth	116	47	49	96	32	16	11	3	12	4	(7)	—	1060	70	6·60	7·17
City of London	11	16	8	24	8	4	1	—	6	2	3	1	333	30	9·01	7·17
	162 †	133	161	294	89	44	34	25	79	22	26	5	1867	...	...	...
Leavesden	36	81	96	177	27	18	30	24	22	18	35	—	1783	...	...	...
Bethlem	71	13	9	22	14	3	1	1	10	—	3	1	264	209	79·17	16·60
St. Luke's	25	7	4	11	5	3	—	1	2	—	2	—	205	70	34·15	16·60
Camberwell	140	28	43	71	...	...	...	...	...	...	...	1	406	30	7·39	9·66
Bethnal House	97	15	21	36	..	...	...	...	...	...	...	...	380	39	10·26	9·66
Hoxton House	95	17	25	42	...	...	...	...	...	...	...	...	279	25	8·96	9·66
Peckham House	202	36	32	68	...	...	...	...	...	...	...	...	302	36	11·92	9·66
Grove Hall, Bow	13	41	—	41	...	...	...	...	...	...	...	...	437	8	1·83	9·66

* Including about 150 who were removed to the Metropolitan Asylums.
† Including 106 children under 16 years of age removed to Hampstead and Clapton Asylums.

COMPARATIVE TABLE OF FACTS IN INSTITUTIONS VISITED, FOR 1875.

NAMES OF INSTITUTIONS.	ADMISSIONS.					RECOVERIES.					DEATHS.				
	SEX.				AGE.	SEX.				AGE.	SEX.				AGE.
	Proportion per cent. of the Sexes in this Asylum.		Proportion per cent. of the Sexes in County & Boro' asylums, Registered hospitals, or Metropolitan licensed houses generally.		Average age at admission.	Proportion per cent. of the Sexes in this Asylum.		Proportion per cent. of the Sexes in County & Boro' asylums, Registered hospitals, or Metropolitan licensed houses generally.		Average age at recovery.	Proportion per cent. of the Sexes in this Asylum.		Proportion per cent. of the Sexes in County & Boro' asylums, Registered hospitals, or Metropolitan licensed houses generally.		Average age at death.
	Males.	Femls.	Males.	Femls.		Males.	Femls.	Males.	Femls.		Males.	Femls.	Males.	Femls.	
C.&B. Asylums*	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.
Brookwood ...	39·82	60·18	48·53	51·47	42·8	55·70	44·30	45·41	54·59	43·2	61·97	38·03	56·66	43·34	49·7
Hanwell.....	56·32	43·68	48·53	51·47	42·2	56·55	43·45	45·41	54·59	40·1	57·72	42·29	56·66	43·34	52·4
Colney Hatch..	30·87	49·13	48·53	51·47	44·8	45·04	54·96	45·41	54·59	40·5	58·87	41·13	56·66	43·34	52·3
Wandsworth..	37·23	62·77	48·53	51·47	41·5	40·54	57·46	45·41	54·59	39·3	48·96	51·04	56·66	43·34	50·6
City of London	60·38	39·62	48·53	51·47	41·7	66·67	33·33	45·41	54·59	40·2	66·67	33·33	56·66	43·34	48·8
M.† Asylums:—															
Caterham	53·50	46·50	...	...	43·9	67·86	32·14	...	...	34·4	45·04	54·76	...	...	52·2
Leavesden ...	50·68	46·32	...	...	...	55·56	44·44	...	...	...	45·76	54·24	...	...	54·9
Hospitals :—															
Bethlem	39·39	60·61	49·23	50·77	35·5	39·02	60·98	40·41	59·59	36·1	59·09	40·91	63·47	36·53	36·4
St. Luke's.....	39·35	67·65	49·23	50·77	41·4	27·91	72·09	40·41	59·59	40·7	61·64	36·36	63·47	36·53	50·3
M. & Houses:															
Camberwell ...	33·62	66·38	44·57	55·43	...	30·00	70·00	40·91	59·09	...	39·44	60·56	54·03	45·97	...
Bethnal	33·88	66·12	44·57	55·43	...	39·39	60·61	40·91	59·09	...	41·67	58·33	54·03	45·97	...
Hoxton	28·25	71·85	44·57	55·43	...	13·51	86·49	40·91	59·09	...	40·48	59·52	54·03	45·97	...
Peckham	45·60	54·38	44·57	55·43	...	39·09	60·72	40·91	59·09	...	52·94	47·06	54·03	45·97	...
Grove Hall	100·00	00·00	44·57	55·43	...	100·00	00·00	40·91	59·09	...	100·00	00·00	54·03	45·97	...

* County and Borough Asylums. † Metropolitan Asylums for Imbeciles. ‡ Metropolitan Licensed Houses.

COMPARATIVE TABLE OF RESULTS IN INSTITUTIONS VISITED, FOR 1875.

	RECOVERIES.								RELAPSES.		DEATHS.							
Proportion per cent. on cases Deemed curable. (a)	Proportion per cent. on cases admitted.	Proportion per cent. on cases admitted in C. & B. asylums, R. hospitals, or M. L. houses generally.	Proportion per cent. on Total number under treatment in each year.	Proportion per cent. on Total number under treatment in each year in C. & B. asylums, R. hospitals, or M. L. houses generally.	Proportion per cent. on Average number resident in each year.	Proportion per cent. on Average number resident in C. & B. asylums, R. hospitals, or M. L. houses generally.	Proportion per cent. on New Cases (n) admitted in current year, and Deemed curable brought over from previous year.	Proportion per cent. on New Cases (n) admitted in current year, and Deemed curable brought over from previous year in C. & B. asylums, R. hospitals, or M. L. houses generally.	Proportion per cent. of Relapsed cases re-admitted on Recoveries.	Proportion per cent. of Relapsed cases re-admitted on Recoveries in C. & B. asylums, R. hospitals, or M. L. houses generally.	Proportion per cent. on cases admitted.	Proportion per cent. on cases admitted in C. & B. asylums, R. hospitals, or M. L. houses generally.	Proportion per cent. on Total number under treatment in each year.	Proportion per cent. on Total number under treatment in each year in C. & B. asylums, R. hospitals, or M. L. houses generally.	Proportion per cent. on Average number resident in each year.	Proportion per cent. on Average number resident in C. & B. asylums, R. hospitals, or M. L. houses generally.
I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.	XVII.
73·83	24·01	34·11	8·11	8·63	11·81	11·28	41·70	35·35	16·99	36·07	21·38	34·38	7·09	8·70	10·61	11·37
64·73	39·84	34·11	6·66	8·63	7·95	11·28	36·34	35·35	15·17	36·07	48·08	34·38	8·04	8·70	9·60	11·37
70·97	35·07	34·11	8·71	8·63	11·69	11·28	36·17	35·35	27·97	36·07	33·48	34·38	8·31	8·70	11·09	11·37
77·21	35·84	34·11	12·46	8·63	17·57	11·28	50·99	35·35	38·67	36·07	19·01	34·38	6·65	8·70	9·32	11·37
44·44	22·64	34·11	6·12	8·63	7·23	11·28	28·92	35·35	12·50	36·07	22·64	34·38	6·12	8·70	7·23	11·37
...	5·76	...	1·19	...	1·52	...	...	...	...	...	60·49	...	12·51	...	15·96	...
...	8·14	...	0·89	...	1·00	...	...	...	...	...	80·54	...	8·79	...	9·86	...
29·08	53·25	37·72	25·63	9·27	46·41	12·21	32·80	29·01	24·39	34·01	9·32	24·01	4·58	5·90	8·30	7·77
28·48	42·16	37·72	15·14	9·27	23·37	12·21	30·07	29·01	37·21	34·01	10·78	24·01	3·87	5·90	5·98	7·77
75·00	38·79	32·24	12·73	9·54	19·48	13·67	37·66	29·24	17·78	26·74	30·60	25·69	10·04	7·60	15·27	10·89
69·86	36·07	32·24	11·40	9·54	16·84	13·67	32·67	29·24	25·76	26·74	19·67	25·69	6·92	7·60	9·18	10·89
59·68	27·41	32·24	8·17	9·54	11·97	13·67	24·67	29·24	8·11	26·74	31·11	25·69	9·07	7·60	13·59	10·89
70·00	30·66	32·24	12·80	9·54	22·70	13·67	30·66	29·24	23·71	26·74	24·82	25·69	10·37	7·60	12·38	10·89
78·38	34·94	32·24	5·38	9·54	6·30	13·67	31·87	29·24	6·90	26·74	49·40	25·69	7·88	7·60	9·19	10·98

(n) This percentage is upon cases "Deemed curable" returned at the close of the previous year, and "Cases deemed curable on admission" [Statistics of Asylum Population, col. iv.]. For method of estimating the numbers upon which the rates for Bethlem and St. Luke's are calculated, see notes to pp. 302 and 320, vol. i.

(o) "New Cases" are "Cases admitted" during the year, *less* cases "Transferred from other asylums" and "Relapsed cases re-submitted," both which have been deducted [Statistics of Asylum Population, col. iii., *less* cols. v. and vi.].

PROPORTIONS OF THE TWO SEXES RECOVERING AND DYING.

THE following tables show the percentages of recovery and death, distinguishing the sexes, to the gross number of admissions, and the total number under treatment, during periods specified, in the institutions visited :—

I. RECOVERIES AND DEATHS TO GROSS NUMBERS OF MALES AND FEMALES ADMITTED.

	Gross number of cases admitted.		Recoveries.		Deaths.		Proportions per cent. to Total number admitted.			
							Recoveries.		Deaths.	
	Males.	Femls.	Males.	Femls.	Males.	Femls.	Males.	Femls.	Males.	Femls.
Five Asylums visited, 1865–75	7660	7851	2231	2564	3080	2513	29·13	32·66	40·21	32·01
Licensed Houses visited, 1865–75 ...	4091	4891	842	1335	1344	1169	20·58	27·30	32·85	23·90
Five Asylums visited, 1831–75	16,854	17,074	4684	5099	6994	5321	27·79	29·86	41·50	31·16

II. RECOVERIES AND DEATHS TO TOTAL NUMBERS OF MALES AND FEMALES UNDER TREATMENT.

	Total number under treatment.		Recoveries.		Deaths.		Proportions per cent. to Total number under treatment.			
							Recoveries.		Deaths.	
	Males.	Femls.	Males.	Femls.	Males.	Femls.	Males.	Femls.	Males.	Femls.
Five Asylums visited, 1865–75	9456	10,504	2231	2564	3080	2513	23·59	24·41	32·57	23·92
Licensed Houses visited, 1865–75 ...	4748	5797	842	1335	1344	1169	17·73	23·03	28·31	20·17
Five Asylums visited, 1831–75	16,854	17,074	4684	5099	6994	5321	27·79	29·86	41·50	31·16

STATISTICAL RETROSPECT OF THE ASYLUMS VISITED.

THE tables included in this section epitomize the statistical returns and computations for each asylum visited, from the date of its opening to the end of 1875. They, in fact, collate the totals of gross and average numbers and proportions returned by the several institutions, and will render it easy to study the experience gained by each asylum, subject to the conditions of its special history, and in recognition of the contingent circumstances which may be supposed to have affected the results.

The condition of age will at once claim attention. The length of time during which an institution—occupied by patients suffering from a malady which has a strong tendency to become chronic, and a widely different rate of discharge, by recovery or death, for the recent and chronic stages—has been in operation, must obviously exercise an important influence upon the percentages of results calculated upon the several bases of "Cases admitted," "Total number under treatment," or "Average number resident." The first two of these computations will, of course, as we are examining the asylums from their dates of opening, be identical; but I have thought it well to distinguish them, because the figures supplied in the columns representing "County and Borough asylums generally," afford a standard of comparison common to the five asylums under review, and the difference due to the age of each institution is clearly brought out by placing the calculations in juxtaposition. The asylum of greatest age on our list is Hanwell, which has been in operation $44\frac{2}{3}$ years. The youngest is Brookwood, with a term of only $8\frac{1}{2}$ years.

STATISTICAL SUMMARY OF THE ASYLUMS VISITED,

STATISTICS OF ASYLUM POPULATION.

NAME OF ASYLUM.	CASES ADMITTED.				CASES RESIDENT.		
	OF ALL CLASSES.			CHRONIC OR RECURRENT.			
	Males.	Females.	Total.	Relapsed cases re-admitted.	Total number under treatment.	Average number resident.	Average number employed.
	I.	II.	III.	IV.	V.	VI.	VII.
Brookwood (8½ years)	1070	999	2069	88	2069	578	369
Hanwell (44⅔ years)	5064	5823	10887	818	10887	1118	602
Colney Hatch (24½ years)	6466	6073	12539	864	12539	1710	787
Wandsworth (34½ years)	3831	3752	7583	807	7583	776	417
City of London (9⅔ years)	423	427	850	38	850	268	167

COMPARATIVE TABLE OF FACTS.

NAME OF ASYLUM.	ADMISSIONS.					RECOVERIES.					DEATHS.				
	SEX.				AGE.	SEX.				AGE.	SEX.				AGE.
	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age on admission.	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age on recovery.	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age at death.
	Males.	Femls.	Males.	Femls.		Males.	Femls.	Males.	Femls.		Males.	Femls	Males.	Femls.	
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.
Brookwood ...	51·72	48·28	49·62	50·38	41·4	48·61	51·39	44·86	55·14	36·8	61·88	38·12	56·04	43·96	49·6
Hanwell	46·51	53·49	49·62	50·38	39·2	41·19	58·81	44·86	55·14	37·0	51·35	48·65	56·04	43·96	49·3
Colney Hatch .	51·57	48·43	49·62	50·38	38·4	52·85	47·15	44·86	55·14	36·1	60·11	39·89	56·04	43·96	45·6
Wandsworth ...	50·52	49·48	49·62	50·38	40·2	48·71	51·29	44·86	55·14	39·4*	59·82	40·18	56·04	43·96	50·7†
City of London	49·76	50·24	49·62	50·38	40·8	47·13	52·87	44·86	55·14	35·6	56·98	43·02	56·04	43·96	47·5

* Average of 7 years, 1869–75 only.

† Average of 11 years, 1865–75 only.

FROM THE DATE OF OPENING TO THE END OF 1875.

STATISTICS OF ASYLUM POPULATION.

CASES DISCHARGED.														CASES REMAINING.
ON RECOVERY.			ON RECOVERY OCCURRING AFTER RESIDENCE OF				DIED.	BY DEATH.			BY DEATHS OCCURRING AFTER RESIDENCE OF				
Males.	Femls.	Total.	Six months, or less.	Between six and twelve months.	Between one and two years.	Between two and three years.	Relieved or Not improved.	Males.	Femls.	Total.	Six months, or less.	Between six and twelve months.	Between one and two years.	Between two and three years.	Remaining in Asylum on Dec. 31, 1875.
VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.	XVII.	XVIII.	XIX.	XX.	XXI.	XXII.	XXIII.
245	259	504	321	89	60	16	244	323	199	522	200	76	84	65	799
1236	1765	3001	1358	907	426	126	1441	2374	2249	4623	1139	509	619	416	1822
1881	1678	3559	1914	964	421	129	2483	2649	1758	4407	1536	625	678	310	2090
1248	1314	2562	1551	590	236	72	1370	1550	1041	2591	876	338	400	214	1060
74	83	157	63	54	24	8	188	98	74	172	50	22	38	20	333

COMPARATIVE TABLE OF RESULTS.

RECOVERIES.						RELAPSES.		DEATHS.					
Proportion per cent. on cases admitted.	Proportion per cent. on cases admitted in County and Boro' asylums generally.	Proportion per cent. ou Total number under treatment.	Proportion per cent. on Total number under treatment in County and Boro' asylums generally.	Proportion per cent. on Average number resident.	Proportion per cent. on Average number resident in County and Boro' asylums generally.	Proportion per cent. of Relapsed cases re-admitted on Recoveries.	Proportion per cent. of Relapsed cases re-admitted on Recoveries in County and Boro' asylums generally.	Proportion per cent. on cases admitted.	Proportion per cent. on cases admitted in County and Boro' asylums generally.	Proportion per cent. on Total number under treatment.	Proportion per cent. on Total number under treatment in County and Boro' asylums generally.	Proportion per cent. on Average number resident.	Proportion per cent. on Average number resident in County and Boro asylums generally
XVI.	XVII.	XVIII.	XIX.	XX.	XXI.	XXII.	XXIII.	XXIV.	XXV.	XXVI.	XXVII.	XXVIII.	XXIX.
24·36	36·32	24·36	33·38	9·82	11·71	17·46	36·00	25·23	34·67	25·23	31·91	10·01	11·57
27·56	36·32	27·56	33·38	5·92	11·71	27·26	36·00	42·46	34·67	42·46	31·91	9·19	11·57
28·38	36·32	28·38	33·38	8·26	11·71	24·28	36·00	35·15	34·67	35·15	31·91	10·41	11·57
33·79	36·32	33·79	33·38	9·06	11·71	31·50	36·00	34·17	34·67	34·17	31·91	9·56	11·57
18·47	36·32	18·47	33·38	6·14	11·71	24·20	36·00	20·24	34·67	20·24	31·91	6·74	11·57

Between these extremes we have Wandsworth, covering $34\frac{1}{2}$ years; Colney Hatch, $24\frac{1}{2}$ years; and the City of London, $9\frac{2}{3}$ years. The figures in columns for County and Borough asylums generally may be taken as standing for about 40 years.

Another condition of moment is the priority of the asylum in respect to its share in the work of a district. There can be no question that this exercises a very important influence on the medical characteristics of an insane population. When there are two asylums in a county, it may be assumed the elder has had time to recover from the disturbing and falsifying effects of a large influx of old cases from the licensed houses, and acute cases sent in preference to the new asylum, as to an hospital. The history of every institution of the class presents four epochs :—1. A period of crowding with old patients, and rush of recent cases; 2. A time during which matters proceed more equably, and the pressure is relieved by sending patients to the licensed houses instead of to the asylum; 3. A term of trial, when, by crowding and enlargement, the need of building a second asylum is staved off, and the existing county establishment is practically reduced to a refuge for incurable cases, with a seasoning of extremely violent patients, whom it is thought better to send to the asylum than to a licensed house; 4. A time of relief, when, the second asylum having been opened, the elder claims the right to rid itself of objectionable cases, and for a brief period enjoys something like a privilege of selection, and commonly asserts its pretensions to be considered an "hospital." The retrospect of the five asylums for Middlesex and Surrey will not inaptly illustrate this picture of asylum history, and it may be worked out conclusively elsewhere.

It is important, therefore, to recognize the position occupied by an asylum in the service of its district. And this must be taken into account, more particularly in studying the proportions per cent. of recoveries, and the death-rate in connection with the two qualifying considerations, namely—the age of the asylum; and the probable life of its inmates, as indicated by the sex and average age on admission. The last-mentioned point I hold to be of great importance in any investigation like that we are pursuing. There must be some standard of reference in every comparative inference. It

matters less what this may be than that it is rigidly used as a constant in the formation of a judgment. The following scale of probabilities will suffice for our purpose; it is computed from Dr. Farr's "English Life Table":—

Age.	Probable Future Life; years.	Age.	Probable Future Life; years.	Age.	Probable Future Life; years.
35 ...	30·0	39 ...	27·4	43 ...	24·7
36 ...	29·3	40 ...	26·7	44 ...	24·1
37 ...	28·7	41 ...	26·0	45 ...	23·4
38 ...	28·0	42 ...	25·4	46 ...	22·7

The sole purpose of the comparison I am about to make is to establish a standard by which the difference of death-rates in several institutions of the same class may be measured. No moment attaches to the degree in which they fall short of the standard arbitrarily employed. It is the degree in which they differ among themselves that concerns us. For example, the probability of life at 38·4—the average age of 12,539 patients admitted at Colney Hatch in twenty-five years—being 27·8, 4407, or 35·15 per cent., died at an average age of 45·6. The proportional loss of probable life, or the measure of failure to reach the standard of expected life at the age estimated, was equal to 26·0 per cent. on the total years likely to be lived by the aggregate number of patients admitted. In other words, 26·0 per cent. of expected life was lost at Colney Hatch. The following table will place this computation for each asylum concisely before the reader:—

NAME AND AGE OF ASYLUM.	Total Admissions.	Average Age on Admission.	Probable Future Life on Admission of each Patient.	Sum of the Years of probable Future Life of total Patients admitted.	Total Deaths.	Average Age at Death.	Sum of the Years of probable Future Life lost by Death in the Asylum.	Percentage of loss of probable Future Life by the total of cases dying.
Brookwood, 8¼ years	2069	41·4	25·7	53,173	522	49·6	9,135	17·2
Hanwell 44⅔ years	10,887	39·2	27·3	297,215	4,623	49·3	79,516	26·8
Colney Hatch, 24¼ years ...	12,539	38·4	27·8	348,561	4,407	45·6	90,784	26·0
Wandsworth, 34¼ years	7,583	40·2	26·6	201,708	2,591	50·7	41,715	20·7
City of London, 9⅔ years ...	850	40·8	26·1	22,185	172	47·5	3,337	15·0
Gross Totals	33,928	39·3	27·2	922,842	12,315	48·3	224,487	24·3

It will be seen at a glance that the calculation is one of

loss of probable life instead of mortality. What I have done is simply to treat each asylum as charged with the guardianship of a certain quantity of probable life, of which a percentage has been lost by death. The proportional amount of each loss may be compared thus :—Brookwood lost 17·2 per cent. of the probable life of its admissions in $8\frac{1}{2}$ years ; Hanwell, 26·8 per cent. in $44\frac{2}{3}$ years ; Colney Hatch, 26·0 per cent. in $24\frac{1}{2}$ years ; Wandsworth, 20·7 per cent. in $34\frac{1}{2}$ years ; and the City of London, 15·0 per cent. in $9\frac{2}{3}$ years. The mean loss equals 24·3 per cent.

These general remarks are intended to suggest lines of research rather than to indicate conclusions.

Colney Hatch supplies the largest number of facts, while Hanwell offers the widest field of inquiry. The career of Hanwell covers, as we have seen, a term of $44\frac{2}{3}$ years, with 10,887 cases, while Colney Hatch, in $24\frac{1}{2}$ years, has had 12,539.

The relative proportions of the sexes in deaths at Colney Hatch have been—males, 61·11 ; females, 39·89. The high rate of deaths on the total of admissions at Hanwell, 42·46, is probably in part due to the length of time the asylum has been in operation, $44\frac{2}{3}$ years; but the standard percentage of deaths for County and Borough asylums in column xxv. is only 34·67, and this, as I have before stated, is calculated on the basis of about 40 years.

The average age on admission has been greater at Hanwell (39·2) than at Colney Hatch (38·4), but at Wandsworth it has been still higher (40·2), and the asylum experience covers nearly 35 years. The proportion of deaths to admissions at Wandsworth is 34·17 ; that is, 0·50 per cent. below the standard (34·67) for County and Borough asylums generally.

The rate of recovery on average numbers resident has been higher at Wandsworth (9·06) than any other asylum, except Brookwood (9·82), which, on account of its age, is scarcely comparable. Neither reaches the standard, 11·71. Colney Hatch stands third on the list, at 8·26; Hanwell fourth, at 5·92.

The gross percentage of recoveries to admissions shows—Wandsworth, 33·79; Colney Hatch, 28·38 ; Hanwell, 27·56 ; Brookwood, 24·36 ; and City of London, 18·47.

AGGREGATE RESULTS OF THE FORTY-FIVE YEARS, 1831-75 (ASYLUMS ONLY).

THE following tables (pp. 82–89) present a general view of the work done in public institutions for the counties of Middlesex and Surrey and the city of London during the forty-five years 1831–75. Previous to that period the care and cure of the insane in these extensive districts rested with the hospitals and licensed houses.

It has not been possible to compile a satisfactory summary of the statistics on record at the Royal Hospital of Bethlem or St. Luke's. The materials I succeeded in collecting were not of a nature to permit the classification which appeared most convenient and desirable. I have therefore thought it better to submit them in abstract in the pages following the tables for the years 1865–74 (pp. 304–324, vol. i.). There they will be found, and the reader can readily compare the results collected by other inquirers with my own. The licensed houses do not either publish reports or, as far as I can learn, keep records more voluminous than those required by the Commissioners in Lunacy, which are neither very precise nor of great medico-economical interest.

Appended to the tables of the licensed houses will be found such details as it seemed well to reproduce, but they do not supply the materials for a summary which could be included in the retrospect now before us. Meanwhile the field offered by the history of the five public asylums is extensive, and it affords scope for the prosecution of researches far beyond my present purpose.

STATISTICS OF ASYLUM POPULATION IN THE COUNTY AND BOROUGH ASYLUMS OF MIDDLESEX, SURREY, AND THE CITY OF LONDON, AS A WHOLE, FROM THE OPENING OF HANWELL ASYLUM IN 1831 TO THE END OF 1875.

Year.	CASES ADMITTED.						CASES RESIDENT.			CASES												DISCHARGED.												CASES REMAINING ON DECEMBER 31ST.				Year.
	OF ALL CLASSES.			RECENT		CHRONIC OR RECURRENT.				ON RECOVERY.			RECOVERIES OCCURRING AFTER RESIDENCE IN THE ASYLUM.									DIS-CHARGED OR RE-MOVED.	BY DEATH.			DEATHS OCCURRING AFTER RESIDENCE IN THE ASYLUM.				ASSIGNED CAUSE.								Total number.	Proportion per cent. of cases Deceased during.	Proportion per cent. of cases Deceased during.	Proportion per cent. of Deaths Deceased during.	
	Males.	Femls.	Total.	Deemed curable on admission.	Transferred from other asylums.	Re-lapsed cases re-admitted.	Total number under treatment.	Average number resident.	Average number employed.	Males.	Fem'ls.	Total.	Six months, or less.	Between six and twelve months.	Between one and two years.	Between two and three years.																							
	I.	II	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.						XVII	XVIII.	XIX.	XX.	XXI.	XXII.	XXIII.	XXIV.	XXV.	XXVI.	XXVII.	XXVIII.	XXIX.	XXX.	XXXI.	XXXII.	
1831	136	159	295	...	...	...	295	200	...	12	8	20										—	13	8	21									254	...	...	...	1831
1832	188	234	422	..	...	19	676	427	...	29	35	64										17	46	53	99									496	...	...	...	1832
1833	90	113	203	...	...	4	699	537	...	26	33	59										5	46	31	77									538	...	...	...	1833
1834	70	52	122	...	...	13	680	564	320	23	25	48										7	33	23	58									567	...	...	...	1834
1835	78	63	141	...	...	33	708	580	380	15	13	28										5	45	26	71									604	...	...	...	1835
													202*	103*	74*	14*																						
1836	67	46	113	...	...	34	717	611	431	18	19	37										5	43	22	65									610	...	...	...	1836
1837	36	27	63	...	...	8	673	608	438	14	13	27										5	24	24	48									593	...	...	...	1837
1838	139	186	325	...	...	...	918	692	492	17	16	33										5	32	38	89									791	...	...	...	1838
1839	123	95	218	...	...	14	1009	803	498	49	39	88										9	45	33	78									834	...	...	...	1839
1840	100	51	151	...	...	20	965	849	528	30	22	52	26	12	19	2						9	38	28	66	5	4	14	7	16	6	10	1	858	...	...	...	1840
1841†	229	292	521	...	...	16	1379	1091	...	33	20	53	30	14	9	2						23	39	56	95	35	10	11	9	5	5	13	2	1208	...	...	...	1841
1842	147	152	299	...	...	19	1507	1248	776	45	48	93	29	36	10	2						20	65	60	125	31	13	29	12	27	13	22	—	1269	...	...	...	1842
1843	150	157	307	...	...	26	1576	1332	700	46	41	87	40	27	16	6						27	53	46	99	26	10	23	11	24	13	8	1	1363	...	...	...	1843
1844	130	85	215	...	...	23	1580	1372	686	24	36	60	34	14	7	1						9	81	42	123	31	15	22	22	30	11	8	—	1388	...	...	...	1844
1845	105	61	166	...	...	12	1554	1382	706	23	21	44	23	14	10	4						20	70	35	105	37	9	13	15	26	11	22	—	1385	...	...	...	1845
1846	96	57	153	...	...	11	1538	1376	738	22	19	41	17	8	9	3						16	73	34	107	21	12	17	11	30	8	19	2	1374	...	...	...	1846
1847	93	71	164	...	...	10	1538	1375	778	36	34	70	43	9	7	4						7	63	31	94	14	9	11	20	16	10	20	4	1367	...	...	...	1847
1848	110	56	166	...	...	12	1535	1357	783	25	24	49	26	7	8	1						13	68	42	110	20	15	11	7	33	5	11	2	1363	...	...	...	1848
1849	250	304	554	...	...	47	1917	1514	957	57	44	101	78	14	6	—						22	62	68	130	38	15	10	7	21	5	11	1	1664	...	...	...	1849
1850	228	211	439	...	...	39	2103	1711	1073	69	82	151	85	40	16	4						52	98	62	160	53	23	26	1	30	15	15	4	1740	...	...	...	1850
1851‡	674	955	1629	...	...	57	3369	2439	...	84	96	180	106	46	11	8						162	99	113	212	89	27	22	21	41	21	22	2	2815	...	...	...	1851
1852	582	502	1104	...	...	72	3919	3066	2072	141	210	351	186	97	41	9						137	203	136	341	153	88	49	15	50	38	45	10	3090	...	...	...	1852
1853	454	394	848	...	...	91	3938	3100	1720	188	172	354	210	75	50	11						120	244	148	392	139	50	113	32	62	36	49	6	3072	...	...	...	1853
1854	467	361	828	...	...	84	3900	3133	2001	156	127	283	162	68	31	7						76	216	142	358	122	58	50	65	51	45	38	3	3183	...	...	9·86	1854
1855	397	273	670	...	...	83	3853	3185	2022	129	114	243	134	65	24	3						67	207	134	341	95	45	56	33	80	41	38	6	3202	...	...	10·19	1855

* These numbers have been estimated for the years 1831–39.

† Wandsworth Asylum was opened June, 1841.

‡ Colney Hatch Asylum was opened July, 1851.

* These numbers have been estimated for the years 1831–39.

STATISTICS OF ASYLUM POPULATION IN THE COUNTY AND BOROUGH ASYLUMS OF MIDDLESEX, SURREY, AND THE CITY OF LONDON, AS A WHOLE, FROM THE OPENING OF HANWELL ASYLUM IN 1831 TO THE END OF 1875—*Continued.*

Year.	Cases Admitted. Of all classes. Males.	Femls.	Total.	Recent. Deemed curable on admission.	Chronic or recurrent. Transferred from other asylums.	Re-lapsed cases re-admitted.	Cases Resident. Total number under treatment.	Average number resident.	Average number employed.	Cases Discharged. On recovery. Males.	Femls.	Total.	Recoveries occurring after residence in the asylum. Six months, or less.	Between six and twelve months.	Between one and two years.	Between two and three years.
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.
1856	368	292	660	...	...	56	3862	3208	...	124	85	209	121	58	22	6
1857	349	333	682	...	...	58	3918	3275	...	112	128	240	131	59	29	7
1858	321	326	647	214	...	67	3914	3279	...	99	111	210	112	58	17	11
1859	581	675	1256	348	...	79	4499	3418	...	165	113	278	164	56	25	10
1860	605	686	1291	194	...	97	5109	3943	...	112	129	241	137	64	20	6
1861	449	544	993	335	...	82	5035	4154	1898	120	146	266	125	90	33	9
1862	426	485	911	334	...	81	5129	4239	2022	165	190	355	161	81	63	27
1863	476	490	966	289	...	70	5250	4392	...	110	184	294	148	78	36	16
1864	476	415	891	316	...	85	5340	4467	...	141	138	279	151	92	15	6
1865	498	530	1028	271	...	74	5477	4566	2046	125	155	280	139	76	37	14
1866*	539	493	1032	207	...	63	5665	4802	2293	118	147	265	128	66	41	12
1867†	628	671	1299	329	...	75	6185	5099	2467	112	158	270	129	77	41	9
1868	581	659	1240	342	...	66	6485	5387	2578	147	196	343	190	91	42	14
1869	600	504	1104	320	98	60	6540	5501	2552	166	173	339	165	103	49	16
1870	680	666	1346	488	166	101	6893	5641	2592	195	210	405	199	114	49	20
1871	1029	1140	2169	546	519	215	7719	5551	2601	234	288	522	266	176	42	15
1872	652	629	1281	546	138	115	7001	5717	2623	253	280	533	262	151	77	14
1873	714	782	1496	457	156	112	7224	5749	2476	218	265	483	253	125	53	30
1874	800	722	1522	683	126	137	7267	5804	2864	335	349	684	384	177	79	14
1875	939	1055	1994	689	415	176	7775	5937	3015	328	343	671	411	163	49	9
Gross number or proportion.	16854	17074	33928	6908‡	7 years 1618	43 years 2615	33928	...	...	4684	5099	9783	5207	2604	1167	351
Average number or proportion.	374·5	379·5	754·0	383·8‡	7 years 231·1	43 years 58·1	754·0	(a) 3450	(a) 2342	104·1	113·3	217·4	115·7	57·9	25·9	7·8

Discharged or removed. Relieved or Not Improved.	By death. Males.	Femls.	Total.	Deaths occurring after residence in the asylum. Six months, or less.	Between six and twelve months.	Between one and two years.	Between two and three years.	Assigned cause. General Paralysis.	Epilepsy.	Pulmonary Phthisis.	Suicide or Accident.	Cases remaining on December 31st. Total number.	Deemed curable.	Proportion per cent. of cases Deemed curable on Total number remaining.	Proportion per cent. of cases Deemed curable in C. & B. asylums generally.	Year.
XVII.	XVIII.	XIX.	XX.	XXI.	XXII.	XXIII.	XXIV.	XXV.	XXVI.	XXVII.	XXVIII.	XXIX.	XXX.	XXXI.	XXXII.	
97	188	132	320	87	38	42	26	85	33	41	4	3236	...	...	14·38	1856
151	158	102	260	78	27	28	19	78	28	39	3	3267	...	...	12·09	1857
170	176	115	291	83	28	37	24	88	31	45	2	3243	128	3·95	10·56	1858
107	177	119	296	95	29	34	19	173	31	40	5	3818	198	5·19	11·20	1859
371	289	166	455	199	74	46	17	80	35	60	7	4042	151	3·74	10·03	1860
151	213	187	400	134	78	77	16	108	31	58	11	4218	220	5·22	11·26	1861
110	203	177	380	117	51	78	38	107	27	48	8	4284	199	4·65	10·26	1862
129	213	165	378	153	39	44	54	105	37	40	6	4449	194	4·36	9·80	1863
134	268	210	478	155	58	66	37	154	34	76	4	4449	231	5·19	10·97	1864
98	261	205	466	143	45	71	36	132	28	71	2	4633	222	4·79	9·87	1865
89	234	191	425	121	53	53	31	124	29	71	6	4886	164	3·36	9·37	1866
241	210	219	429	121	52	60	32	99	34	72	5	5245	223	4·25	8·66	1867
286	215	205	420	124	62	70	27	106	23	70	4	5436	228	4·19	9·23	1868
132	284	238	522	156	53	84	29	119	44	69	5	5547	209	3·77	7·68	1869
393	300	245	545	146	43	78	64	135	43	97	5	5550	288	5·19	8·90	1870
883	333	261	594	211	71	76	36	153	39	78	6	5720	301	5·26	8·89	1871
269	256	215	471	133	79	85	36	125	36	71	11	5728	326	5·69	8·13	1872
442	314	240	554	155	65	83	50	157	29	81	6	5745	276	4·80	7·31	1873
232	329	241	570	193	72	73	51	146	34	76	1	5781	288	4·98	7·47	1874
403	344	253	597	186	84	76	36	120	41	69	2	6104	311	5·10	7·17	1875
5726	6994	5321	12315	3801	1570	1819	1025	3068	988	1713	155	6104*	311*	5·10*	7·17*	Gross number or proportion.
127·2	155·5	118·2	273·7	84·5	34·9	40·4	22·8	68·2	22·0	38·1	3·4	18 years 4938	18 years 231	18 years 4·65	18 years 9·26	Average number or proportion.

Note.—In all instances where the gross and average numbers and rates could not be obtained for the full 45 years the actual period is specified over the figures.

* The City of London Asylum was opened April, 1866.

† The Brookwood Asylum was opened June, 1867.

‡ The total and average in column iv. are for the eighteen years 1858-75. The percentage of curable cases upon the total admissions for the eighteen years is 30·75.

(*a*) Approximate numbers.

* Remaining at the end of 1875.

COMPARATIVE TABLE OF FACTS, COUNTY AND BOROUGH ASYLUMS (MIDDLESEX, SURREY, AND THE CITY OF LONDON), AS A WHOLE, 1831-75.

Year.	ADMISSIONS.					RECOVERIES.					DEATHS.					Proportion per cent. of Recoveries on Deemed curable. (a)
	SEX.			AGE.		SEX.			AGE.		SEX.			AGE.		
	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age at admission.	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age at recovery.	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age at death.	Deemed curable. (a)
	Males.	Females.	Males.	Females.		Males.	Females.	Males.	Females.		Males.	Females.	Males.	Females.		
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.
1831	46 10	53 90				60 00	40 00			...	61 90	38 10			...	...
1832	44 55	55 45				45 31	54 69			...	46 46	53 54			...	...
1833	44 33	55 67				44 07	55 93			...	39 74	40 26			...	...
1834	57 38	42 62				47 92	52 08			...	60 34	39 66			...	...
1835	55 32	44 68	51 60	48 40		53 57	46 43	49 94	50 06	...	63 38	36 62	57 86	42 14	...	...
1836	59 29	40 71				48 65	51 35			...	66 15	33 85			...	...
1837	57 14	42 86				51 85	48 15			...	50 00	50 00			...	...
1838	49 77	57 23				51 52	48 48			...	57 30	42 70			...	...
1839	56 42	43 58	50 89	49 11		53 68	44 32	52 38	47 62	...	57 69	42 31	55 56	44 44	...	...
1840	60 23	39 77	55 44	44 56	36 5	57 69	42 31	50 56	49 42	37 0	57 56	42 42	55 35	44 65	44 5	...
1841	43 95	56 05	49 81	50 19	37 6	60 26	39 74	48 69	51 31	...	41 05	58 95	57 99	42 01	...	...
1842	49 16	50 84	48 18	51 82	41 7	48 39	51 61	48 49	51 51	...	52 00	48 00	54 07	45 13	...	...
1843	48 86	51 14	49 62	50 38	37 7	50 87	47 13	46 42	53 58	...	53 54	46 46	54 03	45 97	...	...
1844	60 83	39 17	...	...	40 4	40 00	60 00	...	...	...	65 85	34 15	...	...	...	...
1845	63 25	36 75	...	...	37 4	52 27	47 73	...	...	...	66 67	33 33	...	...	...	...
1846	62 75	37 25	...	...	40 3	53 66	46 34	...	...	...	68 22	31 78	...	...	...	...
1847	56 71	43 29	...	...	40 8	52 43	47 57	...	...	...	67 09	32 98	...	...	...	...
1848	66 67	33 33	...	...	39 7	51 02	48 98	...	...	...	61 82	38 18	...	...	...	...
1849	45 13	54 87	46 47	53 53	40 4	56 44	43 56	40 00	60 00	...	47 69	52 31	51 42	48 58	...	...
1850	51 94	48 06	49 90	50 10	39 7	45 70	54 30	48 14	51 86	...	61 25	38 75	52 85	47 15	...	...
1851	41 38	58 62	45 97	54 03	40 2	46 67	53 33	43 57	56 43	...	46 70	53 30	54 31	45 69	48 9	...
1852	52 72	47 28	47 87	52 13	39 3	40 17	59 83	45 45	54 55	...	60 12	39 88	50 78	49 22	44 7	...
1853	53 54	46 46	50 43	49 57	38 6	51 41	48 59	44 54	55 46	39 3	62 24	37 76	58 10	41 90	44 8	...
1854	56 40	43 60	49 85	50 15	38 7	52 22	47 78	46 81	53 19	35 8	60 34	39 66	56 24	43 76	46 4	...
1855	59 25	40 75	52 12	47 88	38 6	53 09	46 91	45 80	54 20	34 3	60 70	39 30	58 27	41 73	44 6	...

(a) This percentage is upon cases "Deemed curable" brought over from previous year [Statistics of Asylum Population, col. xxx.], and "Cases deemed curable on admission" [col. iv., *ibid.*].

The proportions of the sexes, and percentages given in the other columns for the years 1831-8, have been derived from the returns of eight asylums, representing, as fairly and fully as possible, the condition of matters in the county generally during the period named. The asylums chosen were those of Bedford, Dorset, Kent, Lancaster, Middlesex (Hanwell), Norfolk, Suffolk, and York (West Riding). The calculations shown are based upon the admissions, recoveries, and deaths from the opening of each asylum to the close of 1838, no other data being available. The same particulars for the years 1839-43, inclusive, are deduced from the annual returns. For the year 1854, and subsequently, the totals given in the Commissioners' reports have been adopted as the bases of computation.

COMPARATIVE TABLE OF RESULTS, COUNTY AND BOROUGH ASYLUMS (MIDDLESEX, SURREY, AND THE CITY OF LONDON) AS A WHOLE, 1831-75.

Year.	Proportion per cent. on cases admitted.	RECOVERIES.								RELAPSES.		DEATHS.				
		Proportion per cent. admitted in County and Boro' asylums generally.	Proportion per cent. on Total number under treatment in each year.	Proportion per cent. on Total number under treatment in County and Boro' asylums generally.	Proportion per cent. on number resident in each year.	Proportion per cent. on number resident in County and Boro' asylums generally.	Proportion per cent. on New Cases (a) admitted in current, and each succeeding year.	Proportion per cent. on New Cases (a) admitted in current, and cases previously brought over from previous year.	Proportion per cent. on New Cases (a) admitted in current, and cases previously brought over from previous year, in County and Boro' asylums generally.	Proportion per cent. on Recoveries.	Proportion per cent. of Relapsed cases re-admitted on Recoveries in C. & B. asylums generally.	Proportion per cent. on cases admitted.	Proportion per cent. admitted in Boro' asylums.	Proportion per cent. on Total number under treatment in each year.	Proportion per cent. admitted in County and Boro' asylums generally.	Proportion per cent. on resident in each year.	Proportion per cent. on resident in County and Boro' asylums generally.
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.
1831	6 78		6 78	...	10 00	...	...	...	...	...	7 12		7 12	...	10 50	...
1832	13 17		9 47	...	14 09	...	...	...	...	...	20 69	...	14 64	...	23 19	...
1833	29 06		8 44	...	10 99	...	...	...	...	...	6 78	...	37 93		11 02	...
1834	30 34		7 56	...	8 32	14 01	...	...	...	...	27 08	...	47 54		8 53	...
1835	19 86	37 51	3 95	...	4 83	13 24	...	...	...	...	11 86	...	50 35	32 21	10 03	...
1836	32 74		5 16	...	6 06	12 93	...	...	...	...	91 89	...	57 52		9 07	...
1837	42 86		4 01	...	4 14	13 55	...	...	...	...	29 63	...	76 19		7 83	...
1838	10 15		3 59	...	4 77	13 67	...	...	...	...	...	...	27 38		9 69	...
1839	40 37	42 25	8 72	...	10 96	14 81	...	...	...	...	15 91	27 45	35 78	36 21	7 73	...
1840	34 44	43 29	5 28	...	6 12	13 60	...	...	...	...	38 46	26 32	43 71	34 30	6 70	...
1841	10 17	34 01	3 84	...	4 86	10 26	...	...	...	...	30 19	28 84	18 23	40 25	6 89	...
1842	31 20	37 61	6 17	...	7 45	10 85	...	...	...	...	20 43	29 77	41 81	38 74	8 29	...
1843	28 34	37 49	5 52	...	6 53	12 23	...	...	...	...	29 89	22 06	32 25	35 98	6 28	...
1844	27 65	...	3 80	...	4 37	...	...	...	...	...	36 68	...	36 68	...	8 39	...
1845	26 51	...	2 83	...	3 18	...	...	...	...	...	27 27	...	63 25	...	6 76	...
1846	26 80	...	2 67	...	2 98	...	...	...	...	...	26 83	...	69 93	...	6 96	...
1847	42 68	...	4 55	...	5 09	...	...	...	...	...	14 29	...	65 48	...	6 64	...
1848	29 17	...	3 19	...	3 61	...	...	...	...	...	24 49	...	65 48	...	7 17	...
1849	18 23	37 25	5 27	...	6 67	10 92	...	...	...	...	46 53	...	23 47	55 10	6 78	...
1850	34 40	41 67	7 18	...	8 83	11 91	...	...	...	...	25 83	...	36 45	35 76	7 61	...
1851	11 05	32 08	5 34	...	7 38	9 15	...	...	...	...	31 67	...	13 01	36 96	6 29	...
1852	31 79	38 62	8 96	...	11 68	9 72	...	...	...	...	20 93	...	30 89	41 06	8 70	...
1853	41 75	35 23	8 09	...	11 42	9 61	...	...	...	...	25 71	...	46 23	40 42	9 93	...
1854	34 18	38 33	7 26	10 07	9 03	13 34	...	...	...	...	29 68	...	43 74	36 45	9 18	9 57
1855	36 27	42 19	6 31	10 23	7 63	13 31	...	...	...	...	34 16	...	50 90	36 92	8 85	8 85

(a) "New Cases" are "Cases admitted" during the year, *less* cases "Transferred from other asylums" and "Relapsed cases re-admitted," both which have been deducted [Statistics of Asylum Population, col. iii., less cols. v. and vi.].

COMPARATIVE TABLE OF FACTS, COUNTY AND BOROUGH ASYLUMS (MIDDLESEX, SURREY, AND THE CITY OF LONDON) AS A WHOLE, 1831–75—*Continued.*

Year.	ADMISSIONS.					RECOVERIES.					DEATHS.					Proportion per cent. of Recoveries on cases Deemed curable. (a)
	SEX.		AGE.			SEX.		AGE.			SEX.		AGE.			
	Proportion per cent. of the Sexes in the asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age at admission.	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age at recovery.	Proportion per cent. of the Sexes in this asylum.		Proportion per cent. of the Sexes in County & Boro' asylums generally.		Average age at death.	
	Males.	Femls.	Males.	Femls.		Males.	Femls.	Males.	Femls.		Males.	Femls.	Males.	Femls.		
	I.	II.	III.	IV.	V.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.	XVII.	XVIII.
1836	53·76	44·74	51·45	48·55	38·2	59·33	40·67	47·61	52·39	37·0	58·75	41·25	56·57	43·43	49·0	...
1857	51·17	48·83	49·86	50·14	38·8	46·67	53·33	45·47	54·53	36·5	60·77	39·23	56·63	43·37	48·1	...
1858	49·61	50·39	48·41	51·59	38·4	47·14	52·86	45·14	54·86	35·4	60·48	39·52	53·85	46·15	46·3	...
1859	46·06	53·74	49·36	50·64	38·0	59·35	40·65	43·57	54·43	35·7	59·80	40·20	55·04	44·16	45·7	56·49
1860	46·86	53·14	47·83	52·17	37·9	46·47	53·53	44·00	56·00	34·2	63·52	36·48	58·36	41·64	46·6	61·48
1861	45·22	54·78	49·23	50·77	39·1	45·11	54·89	43·15	56·85	34·6	53·25	46·75	55·98	44·02	47·0	54·73
1862	46·76	53·24	50·43	49·57	37·0	46·48	53·52	45·40	54·60	36·9	53·42	46·58	55·41	44·59	47·6	64·08
1863	49·08	50·92	49·45	50·55	39·8	37·42	62·59	44·77	55·23	35·9	56·35	43·65	56·89	43·11	47·8	60·25
1864	53·42	46·58	50·03	49·97	38·4	50·54	49·46	45·92	54·08	33·9	56·07	43·93	54·12	45·88	46·3	54·71
1865	48·44	51·56	49·72	50·28	38·3	44·64	55·36	43·75	56·25	36·9	56·01	43·99	56·18	43·82	48·2	55·76
1866	52·93	47·77	49·53	50·47	40·1	44·53	55·47	40·65	59·35	35·4	55·06	44·94	56·57	43·43	47·0	61·77
1867	48·34	51·66	49·50	50·50	40·6	41·48	58·52	41·83	58·17	35·4	48·95	51·05	55·52	44·48	48·2	54·77
1868	46·83	53·15	48·60	51·40	40·1	42·86	57·14	43·15	56·25	35·8	51·19	48·81	53·97	46·03	48·3	60·71
1869	54·35	45·65	50·20	49·80	39·2	48·97	51·03	43·81	56·15	34·3	54·41	45·59	54·91	45·09	48·3	61·16
1870	50·32	49·48	48·85	51·15	40·4	48·15	51·85	44·51	55·49	37·3	55·05	44·95	55·27	44·73	49·4	58·12
1871	47·44	52·56	50·12	49·88	38·7	44·83	55·17	44·20	55·80	37·6	56·06	43·94	56·13	43·87	50·6	60·33
1872	47·62	52·38	48·20	51·80	40·8	47·47	52·53	43·95	56·15	37·0	54·36	45·64	56·95	43·05	47·8	62·03
1873	47·73	52·27	49·42	50·58	40·3	45·13	54·87	43·42	56·51	37·4	56·68	43·32	56·86	43·14	48·8	61·69
1874	52·56	47·44	50·26	49·74	40·5	46·38	51·09	44·12	55·88	37·4	57·72	42·28	56·31	43·69	49·6	71·32
1875	47·09	52·91	48·53	51·47	42·8	48·88	51·12	45·41	54·59	40·4	57·62	42·38	56·66	43·34	51·6	68·08
Gross number or proportion.	49·68	50·32	49 years 45·62	49 years 50 38	...	47·88	52·12	01 years 44 36	01 years 55·14	...	56·79	43·21	56 years 56·04	43 years 43·96	...	...
Average number or proportion.	51·84	48·16	49 years 49·96	49 years 56·04	38 years 39·3	49·36	50·64	44 years 46·17	44 years 53·83	36 years 36·3	57·36	49·64	56 years 56·03	43 years 43·97	48 years 47·6	60·82

(a) This percentage is upon cases "Deemed curable" brought over from previous year [Statistics of Asylum Population, col. xxx.], and "Cases deemed curable on admission" (col. iv., *ibid.*).

COMPARATIVE TABLE OF RESULTS, COUNTY AND BOROUGH ASYLUMS (MIDDLESEX, SURREY, AND THE CITY OF LONDON) AS A WHOLE, 1831–75—*Continued.*

Year.	RECOVERIES.								RELAPSES.		DEATHS.							
	Proportion per cent. on cases admitted in County and Boro' asylums generally.	Proportion per cent. on Total number under treatment in each year.	Proportion per cent. on Total number under treatment in each year.	Proportion per cent. on cases resident in each year in County and Boro' asylums generally.	Proportion per cent. on number in each year.	Proportion per cent. on residents in each year in County and Boro' asylums generally.	Proportion per cent. on New Cases (a) admitted in current year.	Proportion per cent. on New Cases (a) admitted in current year, and Deemed curable brought over from previous year.	Proportion per cent. on Recoveries.	Proportion per cent. of Relapses re-admitted on Recoveries in C. & B. asylums generally.	Proportion per cent. on cases admitted.	Proportion per cent. on cases admitted in County and Boro' asylums generally.	Proportion per cent. on Total number under treatment in each year.	Proportion per cent. on Total number under treatment in each year in County and Boro' asylums generally.	Proportion per cent. on average number in each year.	Proportion per cent. on number resident in each year.	Proportion per cent. on Average number in each year in County and Boro' asylums generally.
	I.	II.	III.	IV.	V.	VI.	VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.	XVII.	XVIII.
1836	31·67	38·19	5·42	9·41	6·52	12·22	...	...	26·79	...	48·48	33·54	8·29	8·27	9·98	10·73	...	...
1857	35·19	38·78	6·03	9·67	7·33	12·49	...	...	24·17	...	38·12	32·17	6·64	8·02	7·94	10·36	...	...
1858	32·46	39·42	5·37	9·77	6·40	12·57	...	...	31·90	...	44·98	33·08	7·43	8·20	8·89	10·55	...	...
1859	29·13	34·94	5·18	9·28	6·28	11·98	...	...	28·58	...	23·57	27·49	6·58	7·76	8·06	10·29	...	...
1860	18·67	30·67	4·72	8·45	6·11	11·26	...	...	40·25	...	35·24	33·13	8·91	8·12	7·54	12·16	...	...
1861	26·79	35·42	5·28	8·33	6·40	11·57	...	...	30·83	...	40·28	33·77	7·94	8·52	...	9·63	11·03	...
1862	30·71	39·28	6·02	8·36	7·06	11·95	...	...	21·82	...	41·72	32·38	7·41	7·85	...	8·96	10·16	...
1863	30·43	36·93	5·60	8·56	6·69	10·81	...	...	23·81	...	39·23	35·29	7·20	8·18	...	8·61	10·42	...
1864	31·31	37·12	5·29	8·67	6·25	11·07	...	...	30·47	...	53·65	39·35	8·15	9·19	...	10·70	11·73	...
1865	27·24	33·88	5·11	8·50	6·13	11·03	...	...	26·43	...	45·33	33·70	8·52	8·46	...	10·22	10·97	...
1866	25·68	35·71	4·68	8·06	5·52	10·23	...	...	23·77	...	41·28	37·57	7·30	8·48	...	8·85	10·76	...
1867	20·70	36·20	4·37	8·38	5·30	10·65	...	...	27·78	...	33·03	36·22	6·94	8·38	...	8·41	10·66	...
1868	27·66	36·10	5·29	8·47	6·37	10·76	...	...	19·24	...	33·87	34·07	6·48	7·89	...	7·80	10·15	...
1869	29·31	37·72	5·21	8·66	6·16	10·56	38·28	32·14	17·70	38·25	47·38	37·70	7·58	8·77	...	9·46	11·17	...
1870	30·09	36·37	5·88	8·54	7·18	10·89	31·44	35·63	24·94	35·19	40·49	36·11	7·91	8·48	...	9·66	10·82	...
1871	24·07	33·78	6·76	8·53	9·40	11·29	30·30	34·49	41·19	37·73	27·39	32·06	7·70	8·10	...	10·70	10·71	...
1872	41·66	37·05	7·61	9·81	9·32	11·18	40·11	36·87	21·58	33·05	36·77	32·83	6·93	7·84	...	8·04	9·57	...
1873	32·29	33·96	6·69	8·02	8·40	10·33	31·08	33·39	23·29	38·68	37·03	35·19	7·57	8·31	...	9·64	10·70	...
1874	44·94	37·90	9·42	8·95	11·78	11·46	41·83	37·31	20·03	33·67	37·45	35·32	7·84	8·34	...	9·80	10·68	...
1875	33·65	34·11	8·63	11·30	11·28	39·68	33·35	36·03	26·23	36·07	29·94	34·38	7·68	8·70	...	10·06	11·37	...
Gross number or proportion.	28·83	40 years 36·22	28 years 28·83	33·38	...	...	42·06	7 years 44·79	26·	36·00	36·30	40 years 34·58	36·30	32 years 31·91	...	...	...	...
Average number or proportion.	29·05	40 years 37·65	28 years 5·88	8·31	7·37	11·71	34·76	7 years 34·39	29·91	36·93*	40·69	40 years 35·31	7·65	8·42	9·00	11·37	...	...

(a) "New Cases" are "Cases admitted" during the year, *less* cases "Transferred from other asylums" and "Relapsed cases re admitted," both which have been deducted [Statistics of Asylum Population, col. iii., *less* col. v. and vi.]. The gross percentage in col. vii. is for the seven years 1869–75; total admissions, 10,911. less 1618 cases transferred and 916 relapsed cases re-admitted; = 8376. To this is added 228, the number "deemed curable" remaining in the five asylums at the end of 1868; = 8604. The recoveries were 3639. The data of the calculation for col. viii. are: "Total admissions during the seven years, 65,470, less 7358 cases transferred and 8407 relapsed cases re-admitted; = 49,665. To this is added 449, the number "deemed curable" remaining in the asylums at the close of the year 1868; = 50,114. The recoveries were 25,353.

* If the five years 1830–43 be included, the average percentage will be 32·26.

The total number of cases reported is 33,928 (col. iii., page 84). The number of "re-admissions" in forty-three years was 2615 (col. vi., page 84). The returns under this last head are defective for 1838, and doubtful in the year 1831, but the total will be amply correct for the forty-five years, if we count the relapsed cases re-admitted 2650. These must be deducted from the gross number of admissions, leaving 31,278. There are no trustworthy records of "cases transferred from other asylums" earlier than 1869. We may therefore reduce the total of admissions for the forty years, 1831–70, by the same percentage which the transfers of the last five years show upon the admissions of that quinquennial period. The allowance will be excessive, because the population as a whole has, of course, increased in mobility as the number of asylums has been multiplied; but the immediate object being to study asylum work as a whole, in its relation to fair opportunities of treatment, the course suggested will be convenient.

The five years, 1871–5, return 1354 cases "transferred from other asylums" in 8462 admissions, that is 16·00 per cent. We may therefore take 16·00 per cent. upon the total 33,928, = 5428, as approximating to the aggregate number of transfers in the forty-five years 1831–75. We have already deducted 2650 from the gross total, 33,928, leaving 31,278, which further reduced by 5428 will be 25,850. This, then, is the net population, or number of *patients*, with which we have to deal in reviewing the medical work of the period 1831–75. The allowance made has been 23·81 per cent. on the admissions reported, and it would be possible, if necessary, to discount the other totals at the same rate, corrected, of course, for the number of years specified, as indicated by the note at the foot of the tables (page 84). Having thus prepared the ground for study, the facts under consideration will, I think, still be found sufficiently numerous, and the reader may handle them with confidence for any calculations outside my own cursory analyses.

Meanwhile, let us notice the general aspect of the figures as they stand.

Sex.

The proportions per cent. of the sexes in admissions have been—males, 49·68; females, 50·32 (cols. i., ii., page 88); the females in each 100 admissions of both sexes being 0·64 more numerous than the males, or one in 156. The proportions in County and Borough asylums generally, for forty years, have been almost identical—males, 49·62; females, 50·38 (cols. iii., iv., page 88); a preponderance of females equal to 0·66, or one in 152 admissions.

The proportions of the sexes shown in recoveries (cols. vi., vii., page 88) are—males, 47·88; females, 52·12; the balance being on the same side as in the admissions, but more considerable. While, as before stated, the proportions of the sexes admitted show an excess of females over males equal to 0·64 in each 100 admissions, or one in 156, the excess of females in recoveries is 4·24 per cent., or one in 24.

Bearing in mind the limits of the argument, it may be inferred that of cases "under treatment"—a description wholly different from cases *occurring*—females have recovered more rapidly than males in the proportion of nearly nine per cent. The computations founded on the percentages for County and Borough asylums generally, based on the data of forty years (cols. viii., ix., page 88), show a similar advantage on the side of the females equal to nearly 23 per cent.

The deaths exhibit greater mortality on the side of the males than on that of the females. In the asylums under review the gross proportions in 100 deaths have been—males, 56·79; females, 43·21 (cols. xi., xii., page 88); excess among the males, 13·58 in each 100 deaths of both sexes, or one in 7·36. In County and Borough asylums generally, for forty years, the proportions were—males, 56·04; females, 43·96 (cols. xiii., xiv., page 88), with a difference of 12·08, or one in 8·27.

Reducing the general results to round figures, we may say —Of 100 patients admitted to the insane population we are examining, 50 have been males, 50 females; of each 100 recoveries 52 were females, and 48 were males; while of each 100 deaths there were 57 males and 43 females. The same formula for county and borough asylums will show 50 males and 50 females admitted; 55 females and 45 males recovered; and 56 males and 44 females died in 100.

Age.

Column v., page 88, gives the mean or average age of cases admitted for thirty-six years. The average is 39·3, but a glance down the column will show variations from 36·5 in the year 1840, to 42·8 in 1875. Speaking generally, there is an apparent tendency upwards, probably due to the growing practice of sending old people from the workhouses into asylums. The rise in average age has been especially notable since 1866. It is obviously impossible to draw any conclusion from the "average age at admission" as to the period at which insanity is most frequent; the conditions which determine removal to an asylum being in some measure unconnected with the disease, and the difference between *occurring* cases and cases "under treatment" strongly marked.

The mean age at recovery is set out in col. x., page 88, for 24 years. The general average is 36·3; the range from 33·9 in 1864, to 40·4 in 1875. In 1853 the mean was 39·3. It does not appear that any great advance has taken place; indeed, on the whole, the "average age at recovery" scarcely seems to have moved with the "average age at admission." This last-mentioned circumstance strengthens my argument that nothing is gained, as regards cure, by sending old cases, or elderly patients, to asylums. Speaking generally, the average age at recovery is below that at admission by something like three years. This will be seen on examining almost any block of years. Additional proof of the folly of crowding asylums with cases past remedy is thus supplied: further evidence can scarcely be necessary. We may read the lesson of statistics on this topic in either of two ways—admissions are, speaking generally, weighted with a drawback of three years on the age factor of probabilities, or asylum progress is impeded to the like extent. And, on the principle of increment, the average age of patients resident in asylums must be rising, the natural death-rate, considered apart from the mortality due to disease, being, of course, raised in proportion.

Column xv., page 88, shows the average age at death for twenty-six years. The mean is 47·6: the range from 44·6 in 1855, to 51·6 in 1875. In the last-mentioned year, as will be seen by the table at page 88, the asylum population

was throughout pre-eminently *old*, in point of age and in every sense. Looking down the column, it will be seen that the tendency is upwards. The mean of the years 1851–5 would be 45·9; that of 1856–60, 47·2; 1861–5, 47·3; 1866–70, 48·5; 1871–5, 49·7. The rise is to some extent due to the increase in the age of admissions, which, during the corresponding quinquennial periods, ran thus—39·1, 38·3, 38·2, 40·1, 40·7. The rise in age at death on the five periods is 3·8; that in the average age at admission is only 1·6, or in the three last periods, 2·5. Something, therefore, must be ascribed to these causes, and, as I have pointed out, there would seem to be a tendency among lunatics—in asylums at least—to live longer than individuals of the class similarly situated did years ago. I have not thought it worth while to devote separate attention to the average length of life in asylums generally, but the tables, placed for convenience on pages 94–5, will show the mean terms of residence in cases discharged—either on recovery or by death—for the seven quinquennial periods in which the discharges are reported. The general effect of the figures is to support the theory that asylum life—at least, in cases ending in death—is longer than it used to be, although neither the recoveries nor the deaths have proportionally increased.

The general deductions, or summaries of analysis, for age may be thus epitomized:—Of 26,154 patients admitted during the period 1853–75, that is in twenty-three years, at the mean age of 39·2, 8047 recovered at 36·3, and 9942 died at 47·8. Dissecting this total and examining it in detail, we find—of 2346 admitted in 1853–5 at an average age of 38·6, 880 recovered at 36·5, and 1091 died at 45·3; of 4536 admitted in 1856–60 at an average age of 38·6, 1178 recovered at 35·8, and 1622 died at 47·2; of 4789 admitted in 1861–5, at the average age of 38·2, 1474 recovered at 35·6, and 2102 died at 47·3; of 6021 admitted in 1866–70 at an average age of 40·1, 1622 recovered at 35·6, and 2341 died at 48·5; and of 8462 admitted in the last quinquennial period, 1871–5, at the average age of 40·7, 2893 recovered at 38·0, and 2786 died at 49·7.

With these observations on the leading facts relating to population, we may examine the records under notice at closer quarters, and with a view to estimate the results obtained by treatment.

DURATION OF RESIDENCE IN CASES DISCHARGED

YEARS.	SIX MONTHS OR LESS.					
	Total number.	Per cent. to total discharged.	Cured.		Died.	
			No.	Per cent. to total cures.	No.	Per cent. to total deaths.
	I.	II.	III.	IV.	V.	VI.
1841 to 1845	316	35·75	156	46·29	160	29·25
1846 to 1850	395	38·99	249	60·44	146	24·29
1851 to 1855	1396	45·70	798	56·55	598	36·37
1856 to 1860	1207	43·11	665	56·45	542	33·42
1861 to 1865	1426	39·88	724	49·13	702	33·40
1866 to 1870	1479	37·32	811	50·00	668	28·53
1871 to 1875	2454	43·21	1576	54·48	878	31·51
Gross numbers and percentages ...	8673	41·37	4979	53·38	3694	31·73
Average numbers and percentages	1239	40·57	711	53·33	528	30·97

YEARS.	BETWEEN TWO AND THREE YEARS.					
	Total number.	Per cent. to total discharged.	Cured.		Died.	
			No.	Per cent. to total cures.	No.	Per cent. to total deaths.
	I.	II.	III.	IV.	V.	VI.
1841 to 1845	83	9·39	14	4·15	69	12·61
1846 to 1850	48	4·74	12	2·91	36	5·99
1851 to 1855	210	6·87	44	3·12	166	10·10
1856 to 1860	145	5·18	40	3·40	105	6·47
1861 to 1865	253	7·07	72	4·88	181	8·61
1866 to 1870	254	6·41	71	4·38	183	7·82
1871 to 1875	291	5·12	82	2·83	209	7·50
Gross numbers and percentages ...	1284	6·12	335	3·59	949	8·15
Average numbers and percentages	184	6·40	48	3·67	136	8·44

ON RECOVERY OR BY DEATH. (*See page* 93.)

BETWEEN SIX AND TWELVE MONTHS.						BETWEEN ONE AND TWO YEARS.					
Total number.	Per cent. to total discharged.	Cured.		Died.		Total number.	Per cent. to total discharged.	Cured.		Died.	
		No.	Per cent. to total cures.	No.	Per cent. to total deaths.			No.	Per cent. to total cures.	No.	Per cent. to total deaths.
VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.	XVII.	XVIII.
162	18·33	105	31·16	57	10·42	150	16·97	52	15·43	98	17·92
152	15·00	78	18·93	74	12·31	121	11·94	46	11·17	75	12·48
619	20·26	351	24·88	268	16·30	447	14·63	157	11·13	290	17·64
491	17·54	295	25·04	196	12·08	300	10·71	113	9·59	187	11·53
688	19·24	417	28·29	271	12·89	520	14·54	184	12·48	336	15·98
714	18·02	451	27·80	263	11·23	567	14·31	222	13·69	345	14·74
1163	20·48	792	27·38	371	13·32	693	12·20	300	10·37	393	14·11
3989	19·02	2489	26·69	1500	12·88	2798	13·34	1074	11·52	1724	14·81
570	18·41	356	26·21	214	12·65	399	13·61	153	11·98	246	14·91

ABOVE THREE YEARS.						TOTAL AT ALL PERIODS.				
Total number.	Per cent. to total discharged.	Cured.		Died.		Total discharged.	Cured.		Died.	
		No.	Per cent. to total cures.	No.	Per cent. to total deaths.		No.	Per cent. to total discharges.	No.	Per cent. to total discharges.
VII.	VIII.	IX.	X.	XI.	XII.	XIII.	XIV.	XV.	XVI.	XVII.
173	19·57	10	2·97	163	29·80	884	337	38·12	547	61·88
297	29·32	27	6·55	270	44·93	1013	412	40·67	601	59·33
383	12·54	61	4·32	322	19·59	3055	1411	46·19	1644	53·81
657	23·46	65	5·52	592	36·50	2800	1178	42·07	1622	57·93
689	19·27	77	5·22	612	29·12	3576	1474	41·22	2102	58·78
949	23·95	67	4·13	882	37·68	3963	1622	40·93	2341	59·07
1078	18·98	143	4·94	935	33·56	5679	2893	50·94	2786	49·06
4226	20·15	450	4·82	3776	32·43	20,970	9327	44·48	11,643	55·52
603	21·01	64	4·81	539	33·03	2995	1332	42·88	1663	57·12

The general features of the summary set out on pages 82–89 are briefly these:—With a total of 33,928 cases under treatment, of which 16,854 were males and 17,074 females, the mean age at admission being 39·3 years, 9783 (4684 males, and 5099 females) recovered at the mean age of 36·3 years, calculated on the basis of twenty-four years, while 12,315 (6994 males, and 5321 females) died at 47·6, computed for twenty-six years.

The gross percentage of recoveries on "admissions" was 28·83, the rate—distinguishing the sexes—being 27·79 males and 29·86 females; the average annual percentage for both sexes, 29·05. Upon the "total number under treatment" the recoveries, of course, showed the same percentage as upon the admissions, because we are reviewing asylums from the date of their opening; but the average annual percentage was 5·88, the difference between this and the gross percentage being explained by the circumstance that the period reviewed was long enough to cover the duration of a large proportion of chronic cases, in addition to the annual average proportion of recent cases recovering. The average annual proportion of recoveries upon the "average number resident," that is the mean population of these asylums, has been 7·37 per cent.

The gross proportion of cases *re-admitted*—to the same asylum—after being discharged either "Recovered," "Relieved," or "Not improved," was 26·73 per cent. upon the total admissions; the average annual percentage, 29·21. It is important to remember that this calculation takes no account of cases which were sent to some other asylum on relapse, instead of being returned to that from which they had previously been discharged. It follows that the proportion per cent. of relapses on admissions generally must be considerably higher than that given, but there is no means of ascertaining the precise figures.

The deaths upon "admissions" produced a gross percentage of 36·30, that is 7·47 in excess of the proportion reached by the recoveries, while the average annual percentage of deaths was 40·69, or 11·64 higher than the corresponding proportion of recoveries. The length of the period under review has the effect of rendering the cumulative result less than the annual rate in the case of percentages of discharge, either by death or recovery, upon "admissions," by enlarging the base of the

calculation. The reason is obvious: by extending the period of observation, you cover the natural duration of cases that run a lengthened course before they terminate, and with each additional year more of such cases are included, which would neither have begun nor ended within a shorter term; but meanwhile, the total of admissions comprised within the period of observation is built up by the accumulation of new cases and relapsed cases readmitted—as much more rapidly than the total of recoveries or deaths as the admissions are more numerous than the discharges—and the percentages of recovery and death therefore gradually diminish. The difference between the annual percentage of deaths on admissions and the gross percentage on admissions for the forty-five years (1831–75), *i.e.* 4·39, is greater than the corresponding difference in the two percentages of recoveries upon admissions (0·22), because the death-rate per annum has been subject to large variations, which in many years forced it to a relatively high point when taken upon the *admissions*.

The average annual death-rate upon number under treatment has been 7·95; that upon average number resident, 11·57. The fluctuations have been considerable; sometimes the rate has been raised by the proportion of elderly patients in the asylums, at others by conditions which increased the general mortality, occasionally by causes peculiar to the special population concerned. The columns for County and Borough asylums generally will supply standards of comparison for the several computations presented.

It has been already shown (page 90) that 25,850 is approximately the net number of *patients* with which we have to deal. In arriving at that figure we made an allowance of 23·81 per cent. It is not necessary, nor do I think it would be accurate, to make the same deduction from all numbers with which this total may be compared. For example, a computation for the forty-five years, obtained by calculating the *gross* number of recoveries (9783) upon the *net* admissions (25,850), shows 37·85 per cent. I believe this figure is not very far wrong, looking to the outcome of the last seven years, at the institutions under notice, and comparing it with the results obtained at the County and Borough asylums generally.

Probably this computation upon "new cases"—as I have

ventured to call them not quite accurately—with those remaining and "deemed curable" at the close of the previous year, is, in theory, as good as any which could be devised. The circumstance that recoveries will happen *chiefly* among the cases which are neither transfers nor relapsed cases re-admitted, justifies the calculation submitted; but no inconsiderable number of the former of these two classes, that is, the "cases transferred from other asylums," as a matter of fact, benefit by the change of scene obtained by removal, and augment the total of recoveries. The percentage of cures upon admissions is on that account, after all, more fairly comprehensive than the new column introduced; and, while glad to have pursued this inquiry round the circle, and feeling it permissible to give the percentage in the tables, the conclusion to which I am now driven is, that the old-fashioned calculation on "admissions" placed side by side with a percentage on the "total number under treatment" affords as trustworthy an indication of the work done, and the progress made, at any asylum, as statistics are likely to furnish, or, indeed, the student need desire.

It follow from the remark just offered, that no serious error is likely to arise from taking the figures as we find them; always carefully noting the length of the period for which the returns are made, and the number of the facts observed.

Length of Residence.

The element of time is of great moment. Dealing first with the—

Recoveries, we find that of 9783 cases returned as recovered in the forty-five years, 5207, or 53·22 per cent., were discharged within six months; 2604, or 26·62 per cent., between six and twelve months; 1167, or 11·93 per cent., between one and two years; 351, or 3·59 per cent., between two and three years; and 454, or 4·64 per cent., more than three years, after admission.

In round figures, rather more than half of those who recovered were discharged within six months. A little over one-fourth of the total number recovered between six and twelve months after admission. About one-eighth were dis-

charged in the second year of residence. Nearly half the remainder recovered in the third year, while a little more than half lingered a lengthened period, but ultimately convalesced.

The cases ending in Death numbered in all 12,315. Of these, 3801, or 30·86 per cent., died within six months of being placed under treatment ; 1570, or 12·75 per cent., after between six and twelve months' residence ; 1819, or 14·77 per cent., in the second, 1025, or 8·32 per cent., in the third year; and 4100, or 33·30 per cent., subsequent to that period. It is noteworthy that while only 30·71 died within six months, a larger number lived on to a period later than that of ordinary recovery—it may therefore be inferred, beyond the natural termination of the disease. In fact, they lived down the malady. This is, however, a very wide observation, for two reasons—the large number of cases dying of general paralysis would necessarily fall outside the three years' limit, if the patients happened to be placed under treatment in an early stage ; and inmates dying of phthisis are not unlikely to have survived it. Meanwhile, it cannot be doubted that the large and increasing proportion of deaths occurring after three years is in great measure due to the fact that the victims of chronic insanity frequently live to ripe old age. The asylums are now crowded with patients suffering from senile imbecility and advanced in the natural term of life.

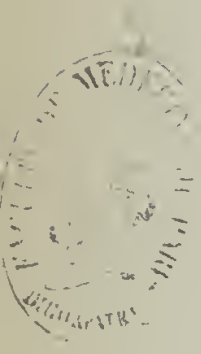
The following table shows, to 100 deaths, the proportions occurring after different periods of residence, for the five years 1841–5, and the three decennial periods following ; together covering the thirty-five years 1841–75, for which the returns are complete :—

Years.	Under six months.	Six to twelve months.	One to two years.	Two to three years.	Above three years.
1841–45 ...	29·25	10·42	17·92	12·61	29·80
1846–55 ...	33·14	15·23	16·26	9·00	26·37
1856–65 ...	33·41	12·54	14·04	7·68	32·33
1866–75 ...	30·15	12·37	14·39	7·65	35·44

From this summary it will appear that—without taking into account the five years 1841–5, which were affected by the opening of Wandsworth Asylum in 1841—the proportion of deaths after residence beyond three years shows a marked increase during the thirty years 1846–75, while the proportion

of deaths after each of the shorter periods of residence has declined.

From the analyses of recoveries and deaths, and the percentages already considered, it is possible to adduce the following synopsis :—Of 100 patients admitted, and forming part of a population of 33,928 (16,854 males and 17,074 females), 28·83 (13·80 males and 15·03 females) have recovered, and 36·30 (20·62 males and 15·68 females) died. Of the 28·83 recovering, 15·35 were discharged in six months, 7·67 between six and twelve months after admission, 3·44 in the second year, 1·03 in the third year, and 1·34 beyond that period. Of the 36·30 dying, 11·20 died within six months, 4·63 between six and twelve months, 5·36 in the second year, 3·02 in the third year, and 12·09 later. Of those discharged as recovered, not less than 26·73 per cent. relapsed. Probably, as we have seen (page 96), this proportion is under-estimated. Of the "new cases" assumed to be admitted for the first time, with those left over as curable from the previous year, 37·85 in 100 recovered. We should scarcely be justified in converting these data into predications, but looking to the figures in the standard columns, the general conditions of probability inferred do not seem to be subject to any serious fallacy.



With these hints as to the lines of inquiry that may be pursued in the investigation, only asking that they shall be considered in connection with the analyses of other tables in this Retrospect, I leave the data collected to the discussion of statisticians. That the materials are susceptible of better manipulation, there can be no question; but I have been more concerned to place them simply before those immediately interested in the care and treatment of the insane, than to elaborate processes which each inquirer may shape for his own purposes, or, to emphasize conclusions which, if I mistake not, appear sharply outlined on the face of the facts.

It is above all things necessary in the investigation of a subject so complex, and so beset with sources of difficulty and error, as that of Lunacy, to secure a rigorous examination of facts. It has been alleged that labour thus bestowed must be fruitless, because the data of the inquiry are themselves vague

and untrustworthy. I think the materials at our disposal have been unreasonably depreciated. They have scarcely been tested and compared. In the Note on Statistics at the close will be found some observations on this subject, to which I beg the reader's attention.

Among the qualifying circumstances which it is necessary to bear in mind, when comparing the statistics of asylum practice to-day with the returns of forty, thirty, or even twenty years ago, are the following :—

1. The base of the calculation for rates of recovery has been extended by the addition of large numbers of cases which are not curable. This has had the effect of reducing the percentage of cures upon "admissions" and "total number under treatment," and of masking any improvement which may have been made. It will be important to keep the fact in mind when attempting to account for the apparent lack of success in raising the rate per cent. of recoveries by better treatment. (See the figures placed in juxtaposition at page 47 of *The Lancet* Commission Report). I should have felt it incumbent upon me to qualify my official statement that "no great improvement has taken place" but for the significant circumstance that, even at the hospitals, where rules excluding incurable cases (vol. i., page 308) have been in force from an early period, the proportion of cures to admissions has not increased. Nevertheless, the considerations I have urged above should have full weight.

2. The death-rate has been raised by classing with the insane in asylums cases of grave physical disease, with which mind symptoms happen, for a time at least, to be associated. Patients labouring under general paralysis, epilepsy, and senile dementia, were rare in asylums thirty years ago; they compose no inconsiderable part of the population in these institutions at the present moment. General paralysis is, of course, a mortal malady, and it contributes largely to the death-rate. Epilepsy may, or may not, be on the increase, but it is certainly represented in asylums by greater numbers now than even twenty years ago. Senile dementia has, I think, no pretence to be admitted to asylums, and as it implies the introduction of patients dying of old age, the effect of including it must be to swell the rate of mortality

These facts deserve due attention. They must obviously modify any inference derived from the figures as they stand. It should also be kept steadily in remembrance that the statistics of lunacy deal only with numbers. *Cases* are not tracked. It is impossible to ascertain the history of any large number of *patients*. Percentages of Recovery, Deaths, Transfer, and Re-admission are therefore nothing more than computations of relative figures, which only in a broad sense represent facts. This is exceedingly unfortunate, but the study of vital statistics is everywhere hampered with the same difficulties and sources of error. There is, however, this advantage in treating of large numbers—that the drawback to accuracy of inference diminishes with each additional thousand of integers included in the sum; and when the field of observation is very large, the error becomes very small.

TREATMENT.

THE subject of treatment is one of especial interest, but the task of compiling a satisfactory retrospect would present difficulties greater than I could hope to surmount. The materials scattered through the asylum reports and returns, official or personal, from which I have cited, will suffice to give a general idea of the progress which has been effected —by the force of circumstances, not less than the increased knowledge and skill of practitioners in lunacy.

It is impossible to overlook the prominent part which public inquiries have played in the development of this branch of medicine. When the Select Committee of 1815 brought to light the routine practice of "physicking," which prevailed even in the Hospital of Bethlem, a laboured attempt to repel the imputation of neglect only emphasized the fact that treatment was then little better than a farce. It is probable the method adopted in certain other institutions may have been more pretentious than that pursued by the physicians of this hospital—for example, the system in force at St. Luke's was less formal and more precise—but the most respectable practice extant at that period possessed scarcely any appreciable claim to be regarded as scientific, and would not for a moment bear comparison with the science of disease and the art of therapy in the domain of general medicine. The publicity given to this state of matters by the Select Committee undoubtedly exerted a beneficial influence. It served to show how completely the obligations of the profession to this particular department of its work were neglected, and the revelation incited physicians and practitioners, engaged in the specialty, to greater enterprise.

The Commissioners in Lunacy have, from time to time, attempted to supply a new impetus to progress. I cannot think they have been altogether successful. It is clearly out-

side the province of a mixed board to deal with the matter of treatment. The circular issued in 1846 elicited replies of scarcely any practical value. They settled no question and advanced no interest. The returns published in the Commissioners' report, dated 1847, do, indeed, convey the impression that certain superintendents were more zealous or acute than their neighbours, but this, I take it, was not what the inquiry was intended to show. When the members of a profession are engaged in a common work, it is no part of the duty entrusted to a board of inspectors to sit in judgment upon the success of individual efforts. The Select Committee of 1815 elicited that insanity was not treated, although the insane were subjected to periodic bleedings and purgings. This fact being demonstrated, and the specialty convinced that something more than the *care* of lunatics was expected of medical practitioners claiming to cure the insane, it remained for Medicine to perform its proper functions. From that moment the business in hand became exclusively professional; and I think it was an act of indiscretion on the part of a non-medical body, like the Commission in Lunacy, to interfere.

The presence of physicians on the Board of Commissioners does not endow that body with medical qualifications, or empower it to discharge professional functions. It is of practical moment this should be clearly understood and constantly borne in mind. In justice to the English Board, I would remark that it appears to have arrived at this conclusion, and credit is due for the sagacity displayed. The reports published in recent years bear testimony to the discretion exercised, and I may be allowed to express a strong opinion that the course pursued by this Commission is one to which it will do wisely to adhere. It seems to me to contrast very favourably with the policy of the Scotch Board, which has apparently yet to learn that, while numbering in its constitution men distinguished for a knowledge of medicine, it is not charged with medical functions and has no official competency to investigate subjects of pathology or treatment. The attempt to wander out of its province must detract from the respect due to the authority of a body whose immediate business is distinctly limited to the super-

vision of general arrangements. It is with sincere satisfaction I have elsewhere quoted a passage from the report of the English Commissioners, dated 1876, in which the intention of making general deductions is expressly repudiated.

All doubt on the question of expediency may be resolved by an unprejudiced perusal of the Parliamentary papers returned to the House of Commons in 1857, when Mr. Otway moved for "Copies of any Communications which have taken place between the Secretary of State for the Home Department, the Commissioners in Lunacy, and the Committee of Visitors of the Surrey Lunatic Asylum, respecting the Case of Mr. Charles Snape, Medical Superintendent of the said Asylum." The question at issue was the administration of a shower-bath with a dose of tartar emetic, followed by the death of the patient. The "cause of death" and the *purpose* of the treatment, doubtless formed fit subjects for inquiry, but when the Board enlarged the scope of the investigation so as to include the question of therapy in relation to the use of certain remedies in a particular class of cases, it became involved in a controversy which masked and vitiated the public issue, while it rendered the retreat of the Commissioners from a false position at once embarrassing and incomplete.

I have dwelt at length on this topic, because I conceive it to be of the highest importance to understand precisely what the functions of a Board of Commissioners really are, that they may be boldly and successfully discharged, while any departure from the plain line of duty is instantly checked and strongly discountenanced. I repeat, the position finally taken up by the English Commission is unexceptionable, and affords the best guarantee for its efficiency as guardian of the interests and welfare of the insane—a helpless and pitiable class of the community, which stands in need of official protection. What I have now to say on the subject of treatment must be understood to be addressed exclusively to medical readers. Before the lay public interested in the care and cure of the insane, I would bear cordial testimony to the zeal and earnestness evinced by the medical superintendents with whom I have been brought in contact. They are manifestly intent upon the relief, and,

where it may be possible, the cure, of this terrible disease in its several manifestations. The methods adopted, while presenting notable features of difference, as viewed from the medical standpoint, are devised and carried out with a single eye to the mitigation of human suffering. The public, the Commissioners, and the lay managers of asylums, must judge by results. Medical knowledge and experience are indispensable to the estimation of the measures employed. Little can be gained by the confounding of questions which have nothing in common.

Speaking generally, it may be said the treatment of insanity is, at the present moment, in a state of great obscurity. The old systems of nosology and therapy are obsolete. Methods which were pursued with confidence until a recent period are no longer trusted; and text-books on the subject of "psychological medicine," "mental disease," and the like, are for the most part useless, if not misleading. I do not think the most erudite treatise which could be produced by an acute and expert alienist, at the present conjuncture, would be in any marked degree better or more serviceable. This is a bold statement to make, and I am prepared to find it challenged; but how should the case be otherwise when, as a matter of fact, no two practitioners are agreed and—which is more important—there are no ascertained bases of agreement, as to the relations of cause and effect in the pathology and phenomena of what some call "mental disease," others "physical disease with mind symptoms"?

The readiest and most voluminous writers on "psychological medicine" and, what is pedantically designated, "mental philosophy," riot in metaphysical speculations: they evolve conceptions of mental derangement from their inner consciousness, and they discourse loquaciously on subjects of abstruse hypothesis. Some go the length of hazarding deductions, which they place before the profession as maxims of medical science; but where, among the formal works treating of insanity, can the student or practitioner put his hand on a trustworthy or intelligible text-book of lunacy in any degree comparable with the systematic dissertations on general medicine in daily use? Nor is this dearth of practical literature to be explained by the lack of materials.

Unhappily, the clinical scope for research on the subject of insanity is well-nigh boundless, and cases of lunacy are more completely and continuously under observation than those of almost any other malady. The truth is, this department of study has been first neglected; then investigated with preconceived opinions, which misled observers; and now it is the scene of wild intellectual excitement, in which the undermining of faiths and the uprooting of moral principles engross a larger share of attention, than the calm elucidation of disease and the patient search for remedies.

It is humiliating to make this reflection, but the interests of science, not less than of truth, enforce the duty of reminding men who, while professedly discoursing on mental disease, are in fact demolishing systems of belief and philosophy, that this is not the enterprise to which Science has called them. I am not the apologist for any particular creed or code of philosophy, but it is impossible to avoid a regret that, instead of sound and practical instruction in the various forms of mental derangement, those to whom we are led to look with not unreasonable expectancy and confidence—inspired by the knowledge of their great powers and attainments—give us a *réchauffée* of the speculations indulged by continental theorists who have, in some instances at least, themselves acknowledged the vanity of the hypotheses with which we are regaled. I think this tangled-wool gathering of contemporary writers on "mental science" and "psychological physiology"—whatever that may be—is deplorable, not only on account of the young men who are misled by it, but the power wasted, while a department of medicine important to the relief of suffering humanity is neglected.

When first it came to be recognized that madness is a disease amenable to treatment, it was only natural that every form of mental derangement should be ascribed to some physical disorder, upon which it was supposed to be directly dependent. The remedies employed were at this stage, consistently, of a character designed to effect physical changes. Even those which might be assumed to act powerfully on the mind aimed to impress it through the agency of the special senses. The reaction brought about—mainly by the instrumentality of men of kindly sympathies, who were ap-

palled by the crude energy, and perceived little beyond the apparent cruelty, of the measures adopted in this physical system—found expression in a method known as "moral treatment," in which violent remedies acting physically were hastily discarded, and nothing but the mildest *régime* and the least immediate of medical agents and appliances were countenanced or employed. It was impossible this *laisser faire* mode of dealing with a formidable malady could be permanently satisfactory. We are now on the threshold, or perhaps I may say in the first stage, of an era which will certainly be characterized by greater activity, and ought also to be distinguished as more scientific. The event must be determined by the direction ultimately given to the force at present employed in surmounting the dead-point.

The power at work is equal to the emergency, and promises well for the future, but the effort lacks guidance. No inconsiderable part of the strength expended seems likely to be wasted on an enterprise which, however respectable in itself, should be treated as amusement rather than work, and engage only the spare energy of the physician. "Mental philosophy" may, no doubt, be conveniently studied through mental derangement, and the latter will probably be the means of elucidating the relations of psychology and physiology; but it is with insanity—as a disease—the science of medicine is primarily concerned. It follows, I think, that the proper line of research is not that which leads to nothing, or to clouds of conjecture—where, far above the heads of the multitude, daring "philosophers" grope for the final elements of mind and the dawn of destiny—but that which will conduct the observer to the humbler, though not less interesting, domain of the direct and discoverable relations between the ascertained facts of physiology and pathology, illustrated in the phenomena of mental disorder and disease. It may be less exhilarating to the intellectual Hercules to grapple with the giant difficulties of this realistic sphere, than to soar in the sublime regions of speculation, but the work nearer at hand is the worthier and the more pressing, and will advantage the stricken creature in whom we are interested more immediately and permanently.

For want of the practical help diverted from the investiga-

tion of insanity, the treatment extant is in theory unintelligible, and in practice capricious. Meanwhile, the most successful physicians are those who adhere closely to the lines marked out by experience. Without being able to conform their diagnoses to any common system of knowledge, they "treat the case." For teaching purposes such a method is, of course, almost useless. It is scarcely possible to formulate the indications of an undefined disease so as to bring it into systematic relations with a particular method of treatment. For example, is catalepsy a symptom common to many forms of insanity, or a formal variety of disease in itself? Is the sort of depression known as melancholia an affection with recognizable shape, or a phase of disorder occurring in the course of totally different morbid processes, and having a diverse significance in each? These may seem inapt illustrations of the difficulty which besets the study and teaching of "mental disease," because every reader will have his own way of answering the questions suggested. I venture, however, to predict that the solutions propounded will differ widely among themselves. No one pursuing anything like an extended course of inquiry as to the views of contemporary writers on lunacy can fail to be struck with the embarrassment which besets the task of reconciling, or even striking a mean of, their differences. It is no uncommon experience to find a physician of ability reporting cases as "catalepsy," more than half of which an equally high authority will claim as "acute dementia," and a third as some totally different affection, while a fourth would scatter them over a wide field of nosology, with a single point of agreement, namely—the *symptom* the first clinical reporter has dignified with the status of a *disease.*

With these preliminary difficulties in the identification of morbid phenomena, it is obviously impracticable to speak of treatment as a system, and idle to think of comparing or contrasting the methods employed. The treatment pursued at most of the institutions I have visited, either for the purposes of the present inquiry or in the study of this absorbing subject as a whole, may be roughly described as dealing almost exclusively with symptoms rather than morbid conditions; and therein practitioners are wise. When science has established definite and intelligible relations between those

conditions and the phenomena with which they are connected, it will be prudent to treat disease. Before these relations are discovered, all treatment addressed to causes must be empirical. The reflex causation of insanity is a fruitful and promising department of research, to which attention should be more carefully directed. In this particular line of exploration, it seems to me there is something to unlearn, and lost or discarded knowledge to regain. The earlier writings on the subject are in advance of the more recent; and in America, at least—where scientific work of great importance and high merit is in progress—alienists are bringing out of their treasure-bags old things of value, as well as new.

For many years past there has been more, if possible, of fashion in the treatment of insanity than in other branches of practice. Remedies and methods of therapy have been extolled and condemned with a celerity and an accord exceedingly remarkable. Some new, or newly applied, drug or device in medicine has been vaunted as a specific, or lauded as a palliative. It has been tried with varying success, when suddenly those who before commended its use have denounced its employment as little short of monstrous. A recital of incidents, which it is not worth while to make, would supply apposite illustration of the way "doctors differ," not only from each other, but from their own expressed opinions.

The tendency to try new drugs characterizes some institutions, while a disposition to trust almost entirely to management is the distinguishing mark of others; and on the whole, unfortunately, I think the last-mentioned policy is attended by—if it does not produce—the most favourable results. The use of narcotic agents is sensibly and everywhere declining.* Better general treatment obviates the recourse to drugs for the relief of special excitement. Powerful remedies, acting directly on the physical or nervous systems, are, as I have before observed, comparatively rarely administered. Among these may be mentioned baths, whether hot or cold, or the two combined. I confess it seems to me that agents of the last-mentioned class are too much neglected. This

* This will be disputed, but I think, while a few physicians are administering *quietness* in the shape of Chloral Hydrate, Croton Chloral, Bromide of Potassium, Hyoscyamine, and similar remedies, largely, the majority are abandoning the practice as, for curative purposes, useless, if not injurious.

is in part the penalty we have to pay for the unreasonable, and I fear unreasoning, criticism sometimes hurled at medical superintendents by censors less familiar with the phenomena of insanity than skilled in the art of fine and fierce writing. The cold-pack, for example, has been denounced and discarded until few have now the courage to employ it.

All such reactions are irrational and faulty. It would be egregious folly to revive the practice of bleeding the population periodically, or of employing the lancet as a universal remedy for inflammatory diseases; but it does not therefore follow that "no blood should be let." The like is true of blistering, the use of emetics, and a host of useful, though sometimes abused, remedies and methods of treatment. Will Science never shake off the fetters with which fashion has hampered her free action? I confess the manly independence of some of the men I have met in lunacy almost reconciles me to—what I conceive to be—their errors. Physicians should, above all things, aim to assert their right of private judgment. It is when men do wrong blindly, ignorantly, or obstinately, in the face of their own obvious convictions, they deserve to be "trounced." It would be a happy day for medicine and the medical profession, if there were more outspoken honesty, and an end of sinister suspicions—with that base imputation of motives, to which no *man* stoops in speech or print. One of the first results of a better spirit among us would probably be the recourse to certain remedies, which it is now the fashion to denounce. In the number of these old-new devices, I think, would be found the cold-pack* for acute mania, perhaps restricted to an earlier stage of the accession than in its former use, and so far modified as to remove constraint from the limbs the instant excitement is subdued, and *before* the patient falls asleep. I do not think the use of sedatives and depressants, even though they may be supposed to react as stimulants or tonics—as in the case of digitalis—would be revived. Opium, certainly, can never again be regarded as a panacea for the evils of *madness*. The wholesale, perhaps I may say indiscriminate, use of this drug in its various forms, which we now stigmatize as an abuse, must be ascribed, first, to ignorance or non-appreciation of its injurious effects—for example, in puerperal mania—and,

* Dr. Sheppard has some excellent and graphic remarks on this remedy in his *Lectures*.

second, to the lack of those less formidable sedatives which have since been introduced. Sedatives, however, as a class, are clearly out of date in asylum practice ; as soporifics, they are, I believe, shown to be needless and mischievous. The judicious administration of suitable food in sufficient quantities, the removal of sources of irritation—*e.g.* darkness, often more disquieting than light—the regulation of temperature, and improved arrangements generally, have been found to induce natural sleep, as compared with which the stupor procured by drugs is worthless, if not disastrous.

There are no new remedies or modes of relief or cure which can be recommended with confidence, and if there were, this is not the place to extol them. I am not writing a treatise on "mental medicine," but a general and, so far as this topic is concerned, very cursory review of the leading facts in connection with the treatment of insanity. It is impossible to formulate the methods employed, and no useful purpose would be answered by describing them in disorder. Looking at the practice as a whole, I think it is weak, inasmuch as it is not sufficiently personal to the case of each patient treated. This remark applies more directly to the moral than the physical plan pursued, as the old custom of dosing patients periodically is extinct. I regret that the routine system of "moral" influences is still in full operation, and not yet generally distrusted. As regards the use of drugs, the practice is either exceedingly homely or empirical. At only a few institutions is the unprofessional and perilous practice of confiding "ward-medicines" to attendants retained. The system cannot be too strongly characterized. It should be everywhere abandoned. Meanwhile, I doubt whether the careful trial of new remedies, and old drugs and appliances in new forms and methods, under close personal observation, and with a distinct scientific intention, is sufficiently general. Clinical study and practice are essential to the exploration of disease in all its forms, and in the department of morbid mental phenomena the need for research and *experiment* is urgent and great. The study of pathology must proceed hand in hand with clinical practice, or the inquiry will be incomplete. On this last-mentioned topic I shall have something to say elsewhere.

FOOD.

MR. C. W. HEATON, Lecturer on Chemistry at Charing Cross Hospital, has done me the favour to examine the dietary lists of the several asylums and hospitals visited, and the more important of the results he has obtained will be found in the annexed tables.

It will be seen that the method adopted has been as complete as the conditions allowed. It was found impossible to estimate the food consumed at the licensed houses, even by pauper patients, with sufficient accuracy to justify the publication of results. The only data obtainable were the total quantities supplied to the entire number of inmates, each person taking, it is stated, as much as may be desired. From these vague premises no fair inference could be drawn. It may, however, be observed, quite generally, that the total food supply at the licensed houses is not very different in quantity or quality from that shown in the tables as the dietary of patients in public and charitable institutions.

The diet lists in full, reprinted from the reports of the several institutions, or communicated, will be found in the Appendix. The following tables epitomize the articles of food, and estimate their elements, as explained in Mr. Heaton's statement.

DAILY DIETARY SCALES IN USE IN 1874.

Solids in ounces, Avoirdupois. Liquids in pints. Heat unit = 1 lb. water raised 1° C. Work unit = 1 ton raised 1 foot = $\frac{\text{heat units} \times 1390}{2240}$.

ASYLUMS.	Days of week.	M. male; F. female; Ex. extra for workers.	Meat uncooked, without bone.	Meat cooked, without bone.	Meat cooked, with bone.	Meat Pie or Pudding.	Meat Stew.	Soup.	Fish.	Bread.	Potatoes.	Other Vegetables.	Cheese.	Butter.	Sweet Pudding or Tart.	Cocoa.	Tea.	Sugar.	Milk.	Tea.	Cocoa.	Beer.	Albuminoids.	Fat.	Carbohydrates.	Salts.	Calorific Equivalent.	Work Equivalent.
							pints.	pints.											pints.	pints.	pints.	pints.					heat units.	foot tons.
Surrey—BROOKWOOD.	Su.	M.	7	...	...	...	...	...	...	16	12		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/2	2·85	2·70	12·75	0·65	5121	3178
Average cost per head per week, 4s. 3·940d.		F.	6	...	...	...	...	...	...	12	10		...	2/3	...	1/3	1/6	1 2/3	2/3	...	...	1/3	2·37	2·45	10·18	0·55	4282	2657
	M.	M.	7	...	...	...	...	...	...	16	16		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/2	...	...	...	...	...	...
		F.	6	...	...	...	...	...	...	12	12		...	2/3	...	1/3	1/6	1 2/3	2/3	...	...	1/3	...	...	...	...	...	...
	Tu.	M.	2	...	...	...	1 1/2	...	...	16	16		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/2	...	...	...	...	...	...
		F.	2	...	...	...	1	...	...	13	12		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/3	...	...	...	...	...	...
	W.	M.	5	...	...	16	...	...	...	15	6		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/2	...	...	...	...	...	...
		F.	4	...	...	12	...	...	...	12	4		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/3	...	...	...	...	...	...
	Th.	M.	7	...	...	...	...	...	...	16	16		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/2	...	...	...	...	..	...
		F.	6	...	...	...	...	...	...	12	12		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/3	...	...	...	...	...	...
	F.	M.	2	...	...	...	...	1 1/2	...	28	...		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/2	...	...	...	...	...	...
		F.	2	...	...	...	...	1	...	22	...		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/3	...	...	...	...	...	...
	Sa.	M.	6	...	...	16	...	...	...	15	6		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/2	...	...	...	...	...	...
		F.	5	...	...	12	...	...	...	12	4		...	2/3	...	1/2	1/6	1 2/3	2/3	...	...	1/3	...	...	...	...	...	...
		Ex.	...	...	...	...	...	...	...	4	...		1	...	...	...	...	...	...	...	...	1/3	0·67	0·30	2·84	0·12	980	608
Middlesex—HANWELL.	Su.	M.	...	5	...	...	...	...	...	15	9		...	1	...	1/2	1/7	1 1/2	1/4	...	...	1/2	2·57	2·79	11·46	0·59	4811	2985
Average cost per head per week, 4s. 3½d.		F.	...	4	...	...	...	...	...	13	8		...	3/4	...	...	2/7	1	1/2	...	...	1/2	2·12	2·04	9·89	0·50	3917	2431
	M.	M.	...	2	...	...	...	1	...	18	...		...	1	...	1/2	1/7	1 1/2	1/4	...	...	1/2	...	...	...	...	...	...
		F.	...	2	...	...	...	1	...	14	...		...	3/4	...	...	2/7	1	1/2	...	...	1/2	...	...	...	...	...	...
	Tu.	M.	...	5	...	...	...	...	...	12	9		...	1	4	1/2	1/7	1 1/2	1/4	...	...	1/2	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	13	12		...	3/4	...	...	2/7	1	1/2	...	...	1/2	...	...	...	...	...	...
	W.	M.	...	3	...	4	...	...	...	12	12		...	1	...	1/2	1/7	1 1/2	1/4	...	...	1/2	...	...	...	...	...	...
		F.	...	3	...	4	...	...	...	10	12		...	3/4	...	...	2/7	1	1/2	...	...	1/2	...	...	...	...	...	...
	Th.	M.	...	...	...	...	...	...	10	15	9		...	1	...	1/3	1/7	1 1/2	1/4	...	...	1/2	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	13	8		...	3/4	...	...	2/7	1	1/2	...	...	1/2	...	...	...	...	...	...
	F.	M.	...	5	...	...	...	...	...	12	16		...	1	4	1/2	1/7	1 1/2	1/4	...	...	1/2	...	...	...	...	...	...
		F.	...	...	...	...	ozs.	...	8	13	8		...	3/4	...	...	2/7	1	1/2	...	...	1/2	...	...	...	...	...	...
	Sa.	M.	...	2	...	...	16	...	...	18	...		...	1	...	1/2	1/7	1 1/2	1/4	...	...	1/2	...	...	...	...	...	...
		F.	...	2	...	...	16	...	...	14	...		...	3/4	...	...	2/7	1	1/2	...	...	1/2	...	...	...	...	...	...
		Ex.	...	...	...	...	...	...	...	3	...		1	...	...	...	...	...	...	...	...	1/2	0·59	0·29	2·35	0·11	844	524
Middlesex—COLNEY HATCH.	Su.	M.	...	5	...	...	...	...	...	16	9		...	1	...	...	...	...	...	1	1	1/2	2·69	2·84	11·85	0·61	4958	3076
Average cost per head per week, 4s. 6⅝d.		F.	...	4	...	...	...	...	...	14	8		...	1	...	...	...	...	...	2	...	1/2	2·25	2·30	10·76	0·53	4292	2663
	M.	M.	...	5	...	...	...	...	...	16	9		...	1	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	14	8		...	1	...	...	...	...	...	2	...	1/2	...	...	...	...	...	...
	Tu.	M.	...	...	...	13	...	...	...	12	9		...	1	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	...	...	13	...	...	...	10	8		...	1	...	...	...	...	...	2	...	1/2	...	...	...	...	...	...
	W.	M.	...	...	...	...	...	...	9	16	9		...	1	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	...	...	...	...	...	8	14	8		...	1	...	...	...	...	...	2	...	1/2	...	...	...	...	...	...
	Th.	M.	...	5	...	...	...	...	...	16	9		...	1	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	14	8		...	1	...	...	...	...	...	2	...	1/2	...	...	...	...	...	...
	F.	M.	...	5	...	...	...	...	...	16	9		...	1	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	4	...	...	pints.	...	...	14	8		...	1	...	...	...	...	...	2	...	1/3	...	...	...	...	...	...
	Sa.	M.	...	...	...	...	1	...	...	18	...		...	1	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	...	...	...	1	...	...	15	...		...	1	...	...	...	...	...	2	...	1/3	...	...	...	...	...	...
Surrey—WANDSWORTH.	Su.	M.	...	8	...	...	...	...	...	16	12	...	...	6/7	...	...	...	...	...	1	1	1/2	2·97	2·98	13·26	0·72	5425	3366
Average cost per head per week, 4s. 2⅝d.		F.	...	7	...	...	...	...	...	12	12	...	...	6/7	...	...	..	...	...	1	1	1/2	2·83	2·79	13·26	0·68	5279	3276
	M.	M.	...	7	...	...	...	...	...	16	12	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	7	...	...	...	...	...	12	12	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	..	...
	Tu.	M.	...	4	...	...	...	...	...	16	12	...	..	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	3 1/2	...	...	...	...	...	12	12	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
	W.	M.	...	...	...	...	...	...	12	16	12	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	...	...	...	...	...	12	12	12	...	..	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
	Th.	M.	...	5	...	...	...	...	...	16	8	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	12	8	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
	F.	M.	...	4	...	...	...	...	...	16	12	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		F.	...	3 1/2	...	...	...	...	...	12	12	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
	Sa.	M.	...	8	...	...	...	...	...	16	12	...	...	6/7	...	...	...	...	...	1	1	1/2	..	...	...	...	...	...
		F.	...	8	...	...	...	...	...	12	12	...	...	6/7	...	...	...	...	...	1	1	1/2	...	...	...	...	...	...
		Ex.	...	...	...	...	...	...	...	4	...	...	1	...	...	...	...	...	...	...	...	1	0·68	0·30	3·71	0·14	1174	729

For Brookwood, Hanwell and Colney Hatch a brace joins the Potatoes and Other Vegetables columns, and each of their figures is printed under both columns.

DAILY DIETARY SCALES IN USE IN 1874 (*Continued*).

Solids in ounces, Avoirdupois. Liquids in pints. Heat unit = 1 *lb. water raised* 1 *C. Work unit* = 1 *ton raised* 1 *foot* = $\frac{\textit{heat units} \times 1390}{2240}$.

ASYLUMS.	Days of week.	M. male; F. female; Ex. extra for workers.	Meat uncooked, without bone.	Meat cooked, without bone.	Meat cooked, with bone.	Meat Pie or Pudding.	Meat Stew.	Soup.	Fish.	Bread.	Potatoes.	Other Vegetables.	Cheese.	Butter.	Sweet Pudding, or Tart.	Cocoa.	Tea.	Sugar.	Milk.	Tea.	Cocoa.	Beer.	Albuminoids.	Fat.	Carbohydrates.	Salts.	Calorific Equivalent.	Work Equivalent.
							pints.	pints.											pints.	pints.	pints.	pints.					heat units.	foot tons.
CITY OF LONDON, *Stone.* Average cost per head per week, 6s. 3d.	Su.	M.	7	...	...	...	...	...	...	16	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	2·83	2·91	13·26	0·68	5347	3318
		F.	7	...	...	...	...	...	...	14	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	2·67	2·88	12·28	0·65	5070	3146
	M.	M.	7	...	...	...	...	...	...	16	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
		F.	7	...	...	...	...	...	...	14	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
	Tu.	M.	3	...	...	...	...	1½	...	20	...	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
		F.	3	...	...	...	...	1½	...	16	...	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
	W.	M.	7	...	...	...	...	...	...	16	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
		F.	7	...	...	...	...	...	...	14	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
	Th.	M.	3	...	...	16	...	...	...	14	8	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
		F.	3	...	...	14	...	...	...	12	8	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
	F.	M.	7	...	...	...	...	...	...	16	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
		F.	7	...	...	...	...	...	...	14	12	...	...	1	...	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
	Sa.	M.	...	...	...	...	...	...	...	14	...	...	...	1	16	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
		F.	...	...	...	...	...	...	...	...	...	...	...	1	14	½	⅐	1⅓	3/10	...	...	½	...	...	...	...	...	...
		Ex.	...	...	...	...	...	...	...	4	...	...	2	...	...	...	...	...	...	...	...	1	1·01	0·55	3·71	0·2	1406	872
Metropolitan Asylums for Imbeciles— LEAVESDEN and CATERHAM. Average cost per head per week, 4s. 1d. * Quantity not stated.	Su.	M.	...	5	...	...	...	...	...	16	10		...	1	...	...	...	...	...	1	1	½	2·70	2·84	12·14	0·62	5025	3118
		F.	...	4	...	...	...	...	...	14	9		...	1	...	...	...	...	...	2	...	½	2·26	2·30	11·05	0·54	4359	2705
	M.	M.	...	...	...	13	...	...	...	12	9		...	1	...	...	...	...	...	1	1	½	...	...	...	...	...	...
		F.	...	...	...	13	...	...	...	10	8		...	1	...	...	...	...	...	2	...	½	...	...	...	...	...	...
	Tu.	M.	...	5	...	...	...	...	...	16	10		...	1	...	...	...	...	...	1	1	½	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	14	9		...	1	...	...	...	...	...	2	...	½	...	...	...	...	...	...
	W.	M.	...	...	...	...	...	...	10	16	10		...	1	...	...	...	...	...	1	1	½	...	...	...	...	...	...
		F.	...	...	...	...	...	...	9	14	9		...	1	...	...	...	...	...	2	...	½	...	...	...	...	...	...
	Th.	M.	...	5	...	...	...	...	...	16	10		...	1	...	...	...	...	...	1	1	½	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	14	9		...	1	...	...	...	...	...	2	...	½	...	...	...	...	...	...
	F.	M.	...	5	...	...	...	...	...	16	10		...	1	...	...	...	...	...	1	1	½	...	...	...	...	...	...
		F.	...	4	...	...	...	...	...	14	9		...	1	...	...	...	...	...	2	...	½	...	...	...	...	...	...
	Sa.	M.	...	...	...	...	1	...	...	16	...		...	1	...	...	...	...	...	1	1	½	...	...	...	...	...	...
		F.	...	...	...	...	1	...	...	14	...		...	1	...	...	...	...	...	2	...	½	...	...	...	...	...	...
		Ex.	...	...	...	...	...	...	...	*	...		*	...	...	...	...	...	...	...	...	1	...	...	...	...	...	...
BETHLEM ROYAL HOSPITAL. Average cost per head per week, 10s. 1¾d.	Su.	M.	...	6	...	...	...	...	...	18	12		...	2	...	...	¼	2	3/10	...	...	1	...	...	...	...	...	...
		F.	...	5	...	...	...	...	...	16	8		...	2	...	...	¼	2	3/10	...	...	½	...	...	...	...	...	...
	M.	M.	...	6	...	...	...	...	...	18	12		...	1	...	...	¼	1	2/10	...	...	1	2·90	2·80	13·64	0·71	5388	3343
		F.	...	5	...	...	...	...	...	16	8		...	1	...	...	¼	1	2/10	...	...	½	2·51	2·51	11·31	0 60	4603	2856
	Tu.	M.	...	6	...	...	...	...	...	18	12		...	1	...	...	¼	1	2/10	...	...	1	...	...	...	...	...	...
		F.	...	5	...	...	...	...	...	16	8		...	1	...	...	¼	1	2/10	...	...	½	...	...	...	...	...	...
	W.	M.	...	6	...	...	...	...	...	18	12		2	1	...	...	¼	1	2/10	...	...	2	...	...	...	...	...	...
		F.	...	5	...	...	...	...	...	16	8		...	1	...	...	¼	1	2/10	...	...	½	...	...	...	...	...	...
	Th.	M.	...	6	...	...	...	...	...	18	12		...	1	...	...	¼	1	2/10	...	...	1	...	...	...	...	...	...
		F.	...	5	...	...	...	...	...	16	8		...	1	...	...	¼	1	2/10	...	...	½	...	...	...	...	...	...
	F.	M.	...	6	...	...	...	...	...	18	12		...	1	...	...	¼	1	2/10	...	...	1	...	...	...	...	...	...
		F.	...	5	...	...	...	...	...	16	8		...	1	...	...	¼	1	2/10	...	...	½	...	...	...	...	...	...
	Sa.	M.	...	...	...	16	...	...	...	18	...		3	1	...	...	¼	1	2/10	...	...	2	...	...	...	...	...	...
		F.	...	...	...	14	...	...	...	16	...		1	1	...	...	¼	1	2/10	...	...	1	...	...	...	...	...	...
		Ex.	...	...	...	...	...	...	...	4	...		1	...	...	...	...	...	...	...	...	1	0·68	0·30	3·71	0·14	1174	729
ST. LUKE'S HOSPITAL. Average cost per head per week, 8s. 6¾d.	Su.	M.	...	...	6	...	...	...	...	22	12	...	...	1	6	½	⅐	1	3/10	...	...	1	...	...	...	...	...	...
		F.	...	...	4	...	...	...	...	20	8	...	...	1	6	½	⅐	1	3/10	...	...	¾	...	...	...	...	...	...
	M.	M.	...	...	...	12	...	...	...	19	...	...	...	1	...	½	⅐	1	3/10	...	...	1	...	...	...	...	...	...
		F.	...	...	...	10	...	...	...	17	...	...	...	1	...	½	⅐	1	3/10	...	...	¾	...	...	...	...	...	...
	Tu.	M.	...	...	8	...	...	...	...	22	...	...	...	1	...	½	⅐	1	3/10	...	...	1	3·28	3·18	13·94	0·70	5773	3582
		F.	...	...	6	...	...	...	...	20	...	...	...	1	...	½	⅐	1	3/10	...	...	¾	2·84	2·77	12·52	0·59	5107	3169
	W.	M.	...	...	...	12	...	...	...	19	8	...	...	1	...	½	⅐	1	3/10	...	...	1	...	...	...	...	...	...
		F.	...	...	...	10	...	...	...	17	6	...	...	1	...	½	⅐	1	3/10	...	...	¾	...	...	...	...	...	...
	Th	M.	...	...	8	...	...	...	...	22	...	...	...	1	...	½	⅐	1	3/10	...	...	1	...	...	...	...	...	...
		F.	...	...	6	...	...	...	...	20	...	...	...	1	...	½	⅐	1	3/10	...	...	¾	...	...	...	...	...	...
	F.	M.	...	...	8	...	...	...	...	22	12	...	...	1	...	½	⅐	1	3/10	...	...	1	...	...	...	...	...	...
		F.	...	...	6	...	...	...	...	20	8	...	...	1	...	½	⅐	1	3/10	...	...	¾	...	...	...	...	...	...
	Sa.	M.	...	...	8	...	...	...	...	22	...	...	...	1	...	½	⅐	1	3/10	...	...	1	...	...	...	...	...	...
		F.	...	...	6	...	...	...	...	20	...	...	...	1	...	½	⅐	1	3/10	...	...	¾	...	...	...	...	...	...
		Ex.	...	...	...	...	...	...	...	4	...	...	1	...	...	...	...	...	...	...	...	½	0·67	0·30	2·84	0·12	980	608

COMPARISON OF ASYLUM DIETARIES (PAST AND PRESENT) WITH THE STANDARDS ADOPTED BY Dr. LYON PLAYFAIR.

	Sex.	Albuminoids.	Fat.	Carbohydrates.	Calorific Equivalent.	Work Equivalent.
Standards.		ozs.	ozs.	ozs.	heat units.	foot tons.
Bare Subsistence	...	2·0	0·5	12·0	3477	2158
Quietude	...	2·5	1·0	12·0	3897	2418
Moderate Exercise ...	...	4·2	1·8	18·7	6293	3905
Active Labour	...	5·5	2·5	20·0	7331	4549
Hard Work	...	6·5	2·5	20·0	7604	4718
Asylums.						
Brookwood	M.	2·85	2·70	12·75	5121	3178
	F.	2·37	2·45	10·18	4282	2657
Hanwell	M.	2·57	2·79	11·46	4811	2985
	F.	2·12	2·04	9·89	3917	2431
Colney Hatch	M.	2·69	2·84	11·85	4958	3076
	F.	2·25	2·30	10·76	4292	2663
Wandsworth	M.	2·97	2·98	13·26	5425	3366
	F.	2·83	2·79	13·26	5279	3276
City of London.....	M.	2·83	2·91	13·26	5347	3318
	F.	2·67	2·88	12·28	5070	3146
For Imbeciles.						
Leavesden	M.	2·70	2·84	12·14	5025	3118
Caterham	F.	2·26	2·30	11·05	4359	2705
Hospitals.						
Bethlem	M.	2·90	2·80	13·64	5388	3343
	F.	2·41	2·51	11·31	4603	2856
St. Luke's	M.	3·28	3·18	13·94	5773	3582
	F.	2·84	2·77	12·52	5107	3169
In 1853.						
Hanwell	M.	3·31	3·18	12·96	5565	3453
Colney Hatch	F.	2·66	3·24	12·28	5272	3271

Mr. Heaton says:—

It was found impossible, and it was also thought unnecessary, to calculate the elements of the dietary for each separate day. One day in each week was therefore selected, upon which the calculation could be made with as little assumption as possible. There seems, however, to be very little difference in the dietetic value of the food of different days.

In many asylums a considerable variety is introduced into the food of the patients, and choice is often allowed between different articles of food. These alternatives are omitted in the tables as tending to render them unnecessarily complex.

The proximate composition of the various articles of food has been calculated chiefly from the simple and excellent table given by Parkes as an epitome of the results of many previous workers. In a few cases other standards have, however, been employed.

The calorific equivalents are, of course, those of Frankland, which have superseded all others. The albuminoids have been reckoned as equal to beef muscle, the equivalent of which is 4368. Fat is taken as equal to beef fat, with an equivalent of 9069, and the carbohydrates as the mean of starch, glucose, and cane sugar, the equivalent being taken as 3530. The unit of work is the foot ton, which seemed preferable as giving smaller figures.

Meat is estimated as moderately fat; that is, as containing 14 per cent. of albuminoids, 19 per cent. of fat, and 3·7 per cent. of salts. Meat cooked with bone is reckoned as equal to the same weight of raw meat, the bone being assumed to balance the loss in cooking. The loss in cooking is taken as 25 per cent. Vegetables, with potatoes, are taken as equal to two-thirds of the weight of potatoes only.

There are some apparent discrepancies in the returns from Wandsworth which make them, perhaps, less trustworthy than the others. In this, as in other cases, the most liberal interpretation possible has been placed upon the figures. Probably the calorific value given is a little too high.

Playfair's standards have been placed in the second table for the purpose of comparison. They were calculated from a great number of dietaries in actual use at the time, and represent the mean quantities found by experience to be consumed by persons in different employments. As such, they are probably more trustworthy than any estimates founded on mere theoretical considerations. Judged by these standards, the force value of all the asylum dietaries is seen to be somewhat low. It would have been even lower, and at the same time, perhaps, more accurate, if beer had not been counted among the articles of food.

It will be apparent from the computations made by Mr. Heaton that the quantities set forth in the scale fall far below the standard of adequacy. I have, in the course of *The Lancet* reports, more than once contended that waste of tissue must be estimated at a somewhat high rate in the case of an average lunatic, and counted as a considerable drain upon the organism and recuperative strength of the excited maniac. It will be seen that in no single instance does the calorific or work equivalent reach the level of "moderate exercise," as fixed by Dr. Lyon Playfair's inductive experiments. This is a significant and momentous fact. I will not offer any opinion as to the true explanation of the circumstance. It may be that the insane do not, taking the average of appetites, desire more than the amount supplied. The results of my inquiry as to the diet of the insane in metropolitan licensed houses, although not sufficiently precise to admit of their publication in a tabular form, seem to bear out the

suggestion just made. It is asserted that the inmates generally have as much as they can eat. If this be so, and I have no reason to question the statement—they appear well nourished—it would seem that, while some individuals may possess voracious appetites, a large number must be content with remarkably small supplies of food, or the average quantity consumed would not be so meagre, as it undoubtedly proves when brought to the test of Dr. Lyon Playfair's standard.

It is, again, remarkable that the quantities have actually decreased since 1853. In the appendix I have given the diets of 1863, but it did not seem worth while to include them in the analysis, as they present no essential difference from those in operation in 1874, which have been submitted to calculation and tabulated.

COST.

I DO not mean to go deeply into this matter, but I shall try to throw together a few of the principal facts relating to the cost of buildings, the charge for maintenance, and other matters, which may help the reader to draw his own conclusions as to the economic value of the work done.

About fifty years ago, as appears from the returns made to the Clerk of the Peace of Middlesex in 1823–24–25, the charge for maintenance, exclusive of clothing, ranged from about 6s. per week at St. Luke's to 10s. at Hoxton (Burrows); the mean was about 8s. In their report dated 1847, which was retrospective, the Commissioners in Lunacy say, "The expense of a pauper lunatic in the county asylums (with the single exception of Chester Asylum, where the cost is as low as 4s. 1d.) ranges from 6s. to 11s. per week." In 1875, at Chester—still at the bottom of the list—the cost was 8s. 4½d. Hull Borough Asylum stood at the top with an expenditure of 13s. 5¾d. The mean was 10s. 0½d. In 1847 the Commissioners took the average for county and borough asylums at 8s. In rough proportions, therefore, the cost has increased 25 per cent. within the last thirty years, or, as I prefer to put it, 20 per cent. of the present expenditure has been added during the last three decades. In 1856 the average presented by the table in Appendix CC. of the Commissioners' reports was 8s. 11⅝d. The increase in twenty years, roundly, has thus been 12·0 per cent.; or 8·9 per cent. of the present expenditure has grown during the period named. Nor has this increase been due to that general rise in prices which has augmented the cost of maintenance generally throughout the country; for in 1856 the expenditure under the head "Provisions" was

4s. 8¼d., while in 1874 the average cost as returned by the Commissioners in Appendix D of their report, under the head "Provisions (including malt liquor in ordinary diet)," was 4s. 9⅝d. In their last report, that for 1875, page 43, the Commissioners give the total average weekly cost, nett, in county asylums at 9s. 9⅞d; in borough asylums, at 11s. 6⅛d. The item "Provisions (including malt liquor in ordinary diet)" is put at 4s. 7d. in county, and 4s. 10¼d. in borough asylums, which, as the latter class of institutions bear the proportion of 49 to 8, would give a mean of 4s. 7⅜d. It is at first sight remarkable that the cost of food should not have played a more considerable part in the augmentation of the general charge. This, however, is explained in the remarks at p. 119–120. Money has been lavished upon the externals, the accessories of treatment, but the fundamental condition of cure by improved nutrition has been neglected.

The following tabular summary of the average costs, for county and borough asylums generally, computed from the annual reports of the Commissioners, will place the data of a judgment on this very important question conveniently before the reader:—

Year.	Provisions (including malt liquor in ordinary diet).	Clothing.	Salaries and Wages.	Necessaries, *e.g.* fuel, light, and washing.	Surgery and dispensary.	Wine, spirits, and porter.	Charged to maintenance account.			Less moneys received for articles, goods, and produce sold (exclusive of those consumed in the asylum).	Total average weekly cost per head.
							Furniture and bedding.	Garden and farm.	Miscellaneous.		
	s. d.	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*
1856	4 8⅜	0 7⅜	1 9⅞	0 11⅜	0 0⅞	0 1⅛	0 4	0 3⅞	0 4⅜	0 3⅜	8 11⅝
1857	4 6	0 7⅜	1 9⅜	0 11	0 0⅞	0 1⅜	0 4⅜	0 4⅜	0 3⅜	0 3⅜	8 9
1864	4 2	0 9	1 9⅜	0 10	0 0⅞	0 1⅜	0 5⅛	0 5⅜	0 3⅞	0 4⅜	8 7⅞
1865	4 3⅛	0 9⅜	1 10⅜	0 10⅜	0 1	0 1⅜	0 4⅞	0 5⅜	0 4⅛	0 4⅜	8 11
1874	4 9⅜	0 9⅞	2 1⅜	1 2⅞	0 0⅞	0 1⅜	0 5⅛	0 6⅜	0 4⅜	0 4⅜	10 2⅜
1875	4 7⅜	0 10⅛	2 1⅜	1 1⅞	0 0⅞	0 1⅛	0 6⅛	0 6⅛	0 4⅜	0 3⅞	10 0⅛

From the figures set out in the above table, it appears that the largest proportional increase on the whole period, 1856–75, has occurred under the head "Garden and Farm." Taking the mean of 1856–7, the expenditure on this item, per patient

weekly, was 4⅛d. The mean of 1874–5 was 6⅝d. This shows an augmentation under that head of 60·6 per cent. During the eight years, 1856–7 to 1864–5, the charge rose 33·3 per cent., from 4⅛d. to 5⅝d. In the ten years, 1864–5 to 1874–5, it has further risen 20·5 per cent. This last increase is not so great as that which is shown by some other items. For example, "Necessaries," comprising fuel, light, washing, etc., which fell between 1856–7 and 1864–5, from 11⅛d., the mean of the two first-named years, to 10⅝d., the mean of 1864–5—that is, 7·9 per cent.—rose in the period 1864–5, 1874–5, from 10⅝d. to 1s. 2⅜d., or 40·2 per cent. Clothing, on the contrary, in the first eight years rose from 7⅝d., the mean of 1856–7, to 9⅜d., the mean of 1864–5, or 23·0 per cent.; while in the last ten years it has risen only 6·7 per cent., or from 9⅜d. to 10d.—the increase on the eighteen years being 31·1 per cent. The same happened to "Furniture and bedding." The mean of 1856–7 under this head was 4⅛d.; that of 1864–5, 5⅜d., 27·3 per cent. higher. The mean of 1874–5 is 5⅝d., showing a further advance of only 9·5 per cent. The most important item, "Provisions (including malt liquor in ordinary diet)," actually fell from 4s. 7⅛d., the mean of 1856–7, to 4s. 2⅝d., that of 1864–5, in the first eight years; that is, 8·2 per cent. During the last ten years, nearly corresponding with the period covered by *The Lancet* inquiry, the expenditure under this head has risen 11·9 per cent., from 4s. 2⅝d. to 4s. 8⅝d. Nevertheless, owing to the fall in the first eight years, the rise in the eighteen is only 2·7 per cent., from 4s. 7⅛d. to 4s. 8⅝d. Against this must, however, be set the increased produce obtained from "Garden and Farm," which to some extent accounts for, and justifies, the greater expense incurred under that head. The "Total average weekly cost per head" has risen 14·2 per cent. in the full term covered by my tables, or 15·2 per cent. during the last ten years, 1864–5 to 1874–5, and only 9·9 per cent. of this increase has gone to feed the patient, and 15·7 per cent. to clothe him.

The reader will be able to make further deductions for himself from the following table, which sets out the fluctuations of increase and decrease in percentages, the more prominent of which I have already noticed. It is fair to state that for

this useful analysis, which will place the facts in a still clearer light, I am indebted to Mr. J. H. Shoveller :—

Year.	Provisions (including malt liquor in ordinary diet).	Clothing.	Salaries and Wages.	Necessaries, *e.g.* fuel, light, and washing.	Surgery and dispensary.	Wine, spirits, and porter.	Charged to maintenance account.			Less moneys received for articles, goods, and produce sold (exclusive of those consumed in the asylum).	Total average weekly cost per head.
							Furniture and bedding.	Garden and farm.	Miscellaneous.		
	s. d.	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*
1856–7 (*mean*) =	4 $7\frac{1}{8}$	0 $7\frac{5}{8}$	1 $9\frac{5}{8}$	0 $11\frac{1}{8}$	0 $0\frac{7}{8}$	0 $1\frac{4}{8}$	0 $4\frac{1}{8}$	0 $4\frac{1}{8}$	0 4	0 $3\frac{6}{8}$	8 $10\frac{3}{8}$
1856–7 and 1864–5*	−8·2	+23·0	+1·7	−7·9	+14·3	+16·7	+27·3	+33·3	0·0	+13·3	−0·8
1864–5 (*mean*) =	4 $2\frac{5}{8}$	0 $9\frac{3}{8}$	1 10	0 $10\frac{2}{8}$	0 1	0 $1\frac{6}{8}$	0 $5\frac{2}{8}$	0 $5\frac{4}{8}$	0 4	0 $4\frac{2}{8}$	8 $9\frac{4}{8}$
1864–5 and 1874–5†	+11·9	+6·7	+15·9	+40·2	−12·5	−14·3	+9·5	+20·5	+9·4	−2·9	+15·2
1874–5 (*mean*) =	4 $8\frac{5}{8}$	0 10	2 $1\frac{4}{8}$	1 $2\frac{3}{8}$	0 $0\frac{7}{8}$	0 $1\frac{4}{8}$	0 $5\frac{6}{8}$	0 $6\frac{5}{8}$	0 $4\frac{3}{8}$	0 $4\frac{1}{8}$	10 $1\frac{4}{8}$
1856 to 1875‡	+2·7	+31·1	+17·9	+29·2	0.0	0·0	+39·4	+60·6	+9·4	+10·0	+14·2

The moral to which these calculations seem to point will be apparent when the considerations submitted in the Section and Note on "Food" have been duly weighed.

In 1846 the sum expended in building, furnishing, and altering nineteen county lunatic asylums was returned to Parliament as amounting to nearly £1,000,000. In their report dated January, 1847, the Commissioners estimated the cost of three county asylums, and thirteen public hospitals not included in the previous return, at "probably not much less than a million;" the aggregate amount annually spent upon the insane in England and Wales, they set down as about £1,000,000, and the capital invested at several millions. This was thirty years ago. The charge has enormously increased since the date of these computations. In 1846 there were in round numbers rather less than 27,000 insane persons

* Say eight years' interval. Increase or decrease per cent.
† Say ten years' interval. Increase or decrease per cent.
‡ Increase per cent. during whole period.

of every class in England and Wales. The numbers returned in 1875 were 64,000. The increase has been 137·0 per cent. in thirty years.

The following is a summary of the entries, in successive annual reports, of expenditure under the heads "building," "repairs and alterations," "furniture, etc.," incurred at the five asylums visited. The first item in each list includes cost of land and the outlay contingent on original construction.

BROOKWOOD.

	£	s.	d.		£	s.	d.		£	s.	d.
1867 ...	105,103	19	3	1870	3023	13	6	1873	3494	11	5
1868 ...	2549	9	10	1871	4028	7	0	1874	3475	11	8
1869 ...	2071	2	0	1872	2959	6	10	1875	3366	0	7

HANWELL.

1831 } 1832 } ...	124,482	0	8	1846	2829	18	2	1861	8840	8	2
1833 ...	538	12	4	1847	4078	12	3	1862	9013	16	8
1834 ...	2085	6	1	1848	4135	9	9	1863	?		
1835 ...	1363	16	7	1849	2776	8	0	1864	6282	14	1
1836 ...	676	11	10	1850	3377	4	3	1865	7123	7	0
1837 ...	921	12	3	1851	2800	5	7	1866	7415	8	3
1838 ...	1459	1	11	1852	3505	10	11	1867	7235	19	11
1839 ...	3586	1	2	1853	4143	3	0	1868	7074	1	5
1840 ...	6081	8	3	1854	4528	8	1	1869	10,115	9	7
1841 ...	7770	3	0	1855	4787	4	11	1870	8135	5	1
1842 ...	8917	5	10	1856	5909	3	3	1871	5648	16	5
1843 ...	7269	8	2	1857	4473	18	11	1872	8045	2	7
1844 ...	5609	11	11	1858	5373	10	1	1873	10,353	7	2
1845 ...	4343	15	9	1859	5145	1	10	1874	11,559	1	1
				1860	?			1875	8942	13	4

COLNEY HATCH.

1851 ...	290,092	6	0	1860	6671	13	9	1869	5958	7	5
1852 ...	3570	3	8	1861	5789	0	4	1870	6152	0	4
1853 ...	2579	4	4	1862	6493	18	1	1871	5541	13	10
1854 ...	4158	10	8	1863	7190	15	0	1872	7471	19	5
1855 ...	4873	3	7	1864	8839	7	6	1873	8043	0	9
1856 ...	5677	9	2	1865	8778	14	5	1874	7671	5	8
1857 ...	5903	8	10	1866	6817	6	4	1875	7591	16	0
1858 ...	5099	6	0	1867	6793	13	2				
1859 ...	5994	4	3	1868	5795	10	9				

WANDSWORTH.

1841 } 1842 } ...	85,366	19	1	1853	4767	10	7	1865	3839	19	8
1843 ...	2116	0	6	1854	5141	4	4	1866	3032	11	7
1844 ...	1587	7	2	1855	2995	4	1	1867	3082	10	5
1845 ...	2334	13	11	1856	3146	13	3	1868	4837	1	5
1846 ...	1336	3	3	1857	3291	4	2	1869	3383	2	6
1847 ...	774	3	6	1 58	2189	8	4	1870	4971	18	9
1848 ...	1614	12	8	1859	3497	4	10	1871	4997	11	4
1849 ...	48,213	12	7	1860	3133	2	7	1872	3898	6	11
1850 ...	3373	3	3	1861	3855	12	2	1873	6153	16	5
1851 ...	2753	10	7	1862	3771	12	7	1874	7671	5	8
1852 ...	2917	4	11	1863	3997	18	11	1875	7199	19	5
				1864	3409	11	4				

CITY OF LONDON.

	£	s.	d.		£	s.	d.		£	s.	d.
1866	714	13	11*	1870	1289	4	11	1874	1006	8	1
1867	810	2	4	1871	665	1	10	1875	2819	12	6
1868	700	14	10	1872	684	5	3				
1869	887	17	7	1873	626	3	0				

I extract a passage from the report of a special committee of the Charity Organization Society, presented to the Council January 15, 1877, and since printed :—

	£	s.	d.
Amount expended in "building, fitting up, and furnishing" Leavesden Asylum	173,033	3	1
Accommodation for 2000 patients, cost per bed therefore equals ...	86	10	4
Amount expended at Caterham Asylum for the above purpose ...	182,129	5	4
Accommodation for 2000 patients, cost per bed therefore equals ...	91	1	3
Cost per head, for all charges except rent, for half-year ended at Michaelmas, 1876, Leavesden ... ... weekly		7	3½
Ditto ditto Caterham ... ... weekly, nearly		9	0

The higher rate at Caterham is mainly owing to extra expense of conveyance and water-supply occasioned by the situation of the asylum. The entire expenditure is defrayed from the poor-rate—the "Establishment charges" from the Metropolitan Common Poor Fund, and the "Maintenance charges" direct from each union or parish, in proportion to the number of patients sent. The charge for "Building and Permanent Works" is provided for by loans from the Metropolitan Board of Works, the repayment of which is spread over sixty years.

With the proposals of this committee for the care and employment of harmless lunatics, *properly so called*, and the training of idiots and imbeciles, I am in general accord. The point on which I differ is the recommendation that the jurisdiction of the Local Government Board should be retained. I think it is desirable—I will even say essential to success—that these institutions should be under the immediate and sole control of the Commissioners in Lunacy. The report is signed by the Earl of Devon ; the Earl of Lichfield ; Lord Wrottesley ; the Hon. C. H. Strutt ; Sir John Ogilvy, Bart. ; Sir Alexander Acland-Hood, Bart. ; Lieut.-General Orfeur Cavenagh ; F. H. Dickinson, Esq. ; W. H. Pole Carew, Esq. ; Dr. Brewer ; Sir Charles Trevelyan, Bart., K.C.B., as hon. secretary ; and C. S. Loch, Esq., secretary to the Council.

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* The original cost of this asylum does not appear in the first report.

NOTES.

NOTES.

ON THE ASYLUM QUESTION.

I.—*THE DIFFICULTY.*

An asylum population will always increase in greater ratio than the general increment of insanity when, besides admitting recent cases in the proportion, of that increment, to its capacity, it receives patients whose malady is of some standing. This fact is frequently overlooked; and successive estimates of "accommodation required" being based on the general rate of increase—shown by a progressive series of numbers collected from the annual returns of pauper lunatics—in the district as a whole, provision is no sooner made than it is found to be inadequate.

Supposing the total number of pauper lunatics in a county—including all known cases without regard to their distribution—to have risen in ten years from 1252 to 2007, that is 755: the total increase would be 60·30 per cent., the mean increment 6·03. If we assume that 1382, or 68·86 per cent. of the 2007, are lodged in asylums and licensed houses, and the previous rate of increase is maintained, additional accommodation must be provided to the extent of 1321 beds in the next ten years, at the mean rate of 132 per annum. The pressure from without will increase in precisely the same proportion, nothing having been done for its relief. Meanwhile, every chronic case transferred to the asylum, although

not an integer in the sum of increase as regards the total of insanity in the county, will add a unit to the increase of the asylum population, and each unit thus added will count for more than unit—as much more, proportionally, as the total number of pauper lunatics in the county may be greater than the number contained in the asylum; *e.g.*, one per cent. on the total of insane paupers in the district will count two per cent. on the population of an asylum which contains only half that total.

Recent and recurrent cases alone compose the general increment of insanity. Each new case of recurrent disease counts as three for the purposes of a ten years' census of insanity. An asylum population fed with other elements than these is absorbing old material, not dealing with new. In so far as it is performing this function, the service rendered may be philanthropic, possibly even socially prudent, but it is not medical, and must be thrown out of account when estimating the value and success of a curative enterprise.

The rate at which this taking in old cases may progress is governed by no law. Considerations of finance and policy determine the course pursued, and the only important point to notice is the need of guarding against a false inference from the statistical results returned. The extension of an institution so conducted can throw no light on the progress of mental disease, nor does the pressure on its space bear any certain relation to the increase of insanity in a particular district. A single reflection will make this clear. If all, or nearly all, the new cases occurring in a county or borough are sent to an asylum which does not previously contain all the old cases, the cases admitted will bear a higher proportion to the asylum population than to the "total number of the insane" in the district, which includes those outside, as well as those within, the asylum. If, as we further assume, the asylum is absorbing old cases, as well as taking in new, the increase of its admission rate will be largely in excess of the general increase.

There are, also, special causes at work within an asylum population which tend to make it grow more rapidly than the increase of insanity in a district or in the country would explain. The mean length of life among the insane in

asylums is greater than it was thirty or fifty years ago, as shown by the higher average age at death. This is in part due to the improved conditions of life in asylums, and in part accounted for by the circumstance that a larger number of patients attacked with mental disease survive the acute stage, now that the treatment is less violent, and the risks to life are fewer than they were years ago. Probably, also, a greater proportion of cases which have lived beyond the active stage of a first attack of mania pass, unnoticed and unhelped, through the phase of acute or subacute dementia which often supervenes, and either sink directly into the class of incurable imbeciles, or, being only partially cured, return to the ranks of the insane again and again as subjects of recurrent disease.

It is one of the disadvantages accruing to the modern system of treatment, which is, indeed, scarcely a system, that cases are too frequently allowed to drift, if only quiet wards, a low death-rate, and a fair proportion of discharges, describable as "recoveries," can be secured. It is not that cases are neglected: they are simply overlooked. The subsidence of a paroxysm of acute mania, developed to its highest pitch of violence by opposition under the old system of restraint, was like the crisis in "brain fever." It could not pass unnoticed, and was generally the signal for an entire transformation in the scene and circumstances of the patient. He was liberated from his bonds, clothed, and transferred from a community of raving maniacs to the companionship of convalescents in comparative tranquillity.

The change was strongly marked and complete. In itself this procedure arrested the patient's attention, exerted a powerfully stimulating effect on his recuperative powers, and helped forward the cure. Under the prevailing *régime* there is no such change. Carefully protected from irritation in the earlier stages of the complaint, surrounded by objects of a soothing character, recovery, when it occurs, is commonly gradual. The awakening takes place under conditions which excite little emotion and produce no lasting impression. Often the moment which of all others is critical in the course of the disease passes unobserved. Even the existence of such a crisis is questioned or denied. Simple bewilderment,

ending in exhaustion, conducts the patient quietly down to the depths of imbecility; or, unaided, the restorative force proves insufficient to lift the mind on shore, and chronic helplessness ensues. This is a terrible reflection, but it is one that cannot with safety be disregarded. The apparent increase of insanity in the county is probably in part of the nature to which this consideration points.

It is doubtful whether a larger proportion of the population are attacked with mental disease, but more of those who become insane remain so, than in the days when the victims of insanity were "cured" or "died" rapidly, neither lingering so long, nor gliding so insensibly into the darkness of dementia, with mental faculties at first only dazed by exhaustion, but finally failing because unaroused.

II.—*THE PROBLEM.*

If there be any means of reducing the number of persons attacked with mental disease, it lies beyond the reach of those upon whom devolves the care and cure of the insane. We are not now concerned with the precautions which may be taken against hereditary disease, or the measures of social prudence and reform which would perhaps help to minimize the exciting, possibly even the predisposing, causes of insanity. Our immediate attention is limited to the solution of a problem which may be thus defined: To cure the curable, and place the chronic under efficient and humane care.

It is useless to discuss the question of insanity as a disease requiring treatment, unless we believe it to be susceptible of cure. Unfortunately there is widespread, and it is to be feared enervating, scepticism on this point. If the task, devolving on those who strive to grapple with the evil, consisted merely of an endeavour to ameliorate the condition of patients afflicted with an incurable malady, the medical question involved would scarcely deserve the attention it has received. Those who have studied lunacy with the resulting conviction that insanity cannot be cured, may be excused for the apathy they display in dealing with it; but on the ground of common humanity, and in the interests of science,

they should stand on one side, and let men with more faith take the field against an enemy increasingly active, if not increasingly strong. Doubt as to the business before them must clearly do much to embarrass the enterprise of asylum committees; and medical men who, by their words and policy, contribute to the uncertainty, help to hamper progress, and cannot reasonably complain if there is little advance.

Nothing I could urge would be likely to impress physicians who, after great experience and manifold pains, have arrived at the conclusion that mental disease is incurable. The corollary to that proposition must, or ought to, be that it is not worth while to waste money in the attempt to cure. In reply to such a contention there would be little to urge. If the case stand thus, the utmost claims of humanity will be satisfied by some decent provision for the safety and comfort of the insane—as a troublesome and burdensome class of the community, of whom we can scarcely hope to rid ourselves and to whom it is necessary to be kind. Nothing in this work is intended to bear upon the question of insanity thus regarded. The doctrine of incurability is, in my judgment, discreditable to even ordinary powers of observation, and scientifically absurd.

The problem consists of two parts, and I believe they not only ought to, but must, be considered apart. It seems to me impossible to proceed a step in the search for a solution without roughly, at least, discriminating between those cases which may be cured and those which are probably incurable. If no other consideration rendered some classification of the kind indispensable, it would be necessary on the score of expense. It is impossible to provide the costly appliances required in treatment, for all the insane, and by attempting too much many well-intentioned efforts for the cure of insanity have signally failed. Perhaps to the magnitude of the effort made to extend the benefits of the asylum system to "all the insane" in a county or borough may be ascribed the discouraging circumstance that, notwithstanding the advantages of modern discovery and improvement, scarcely a fractional increase in the proportion of cures has been effected during the last thirty years. Sceptics point to this as the proof that insanity cannot be cured; I prefer to regard it as evidence

that we have not yet discovered the best mode of treating the disease.

As a matter of fact, the discrimination between curable and incurable cases is attempted; but, unfortunately, in a fashion which gives no certainty of success, or even safety, to the patient. The task is wholly beyond the physician's diagnostic skill. It cannot be accomplished by an arbitrary process of exclusion like that adopted by medical superintendents, who, for the purpose of making an annual return to the Commissioners, write off certain maladies as incurable, and thus create a rule of thumb to which, as to most rules, there are, happily, many exceptions.

III.—*THE SOLUTION.*

If it be admitted that the problem is to cure where cure is possible, the experiment of treatment must be fairly tried in all cases of mental disease, and only abandoned when the effort has undoubtedly failed. The doctrine that curable cases will, at least, begin to show some token of amendment within twelve months after admission is in the main sound. The large proportion of cases recovering within six or nine months' residence in an asylum proves how often this opinion holds good; but the circumstance that many recover in the second or even the third year—a few much later—supported by the significant fact that the proportion of cures to the total number under treatment increases in something like geometrical proportion when computed upon a long series of years, goes to show that it is impossible to fix any arbitrary limit passing which a case becomes incurable.

This last-mentioned circumstance has been adduced as an argument against the proposal to brand any class of cases as incurable and place them under separate care. Such a proposal must clearly be opposed to the interests of cure, and therefore of economy. It is scarcely surprising that it should have encountered strong objections, not only in this country, but elsewhere. It has nothing in common with the plan I have incidentally suggested in the course of the foregoing reports, and which may now be stated more specifically thus: —To provide in every district an hospital, properly so called

and thoroughly furnished with all necessary appliances for the physical and moral treatment of insanity. Attached to this hospital, so far as the control of its general arrangements is concerned, construct an institution—or, if necessary, more than one—to which patients not either requiring, or likely to be benefited by, active personal treatment, but still needing medical care, may be removed, when in the course of each individual case, it becomes apparent, that this transfer will not prejudice the final chances of recovery. In connection with the workhouse, or in some appropriate institution—for example, a "workhouse asylum"—provide suitable wards for the senile and infirm, whose recovery is impossible, and who tarry only for death.

This threefold system being efficiently organized, the necessary circulation of cases may be readily maintained, without either indefinitely multiplying costly buildings, or allowing the curative establishment to become blocked against recent and curable, by the stagnation of chronic, cases. There would, moreover, be this great advantage in the plan suggested: the capacity of the hospital required in any district could be determined, not on a vague conjecture as to the probable rate of increase in the total number of pauper lunatics, but upon the more definite and, though neglected, not impracticable, basis of the number of persons becoming insane.

In Middlesex the admissions to the asylums at Hanwell and Colney Hatch, during the year 1875 amounted to 1054. The discharges and deaths were 1044. Probably about 30 per cent. of these case-endings occurred within six months of admission. The average number resident in the county asylums is now 3906. The accommodation required, for new cases only, would certainly not exceed 1000 beds for the entire county. In Surrey, the total of admissions in the same year at the two asylums, Wandsworth and Brookwood, numbered 834. The discharges were 568, of which something like 30 per cent. would take place within six months. There was an average number resident of 1699 in the asylums. An hospital with 600 beds would probably meet the utmost demands of the county for recent cases and the strict purposes of cure. Something should be added to the above calculations for the pauper cases sent direct to licensed

houses, but it is difficult to determine what precise allowance to make. The general argument is not, however, affected.

One curative establishment—or, still better, two—in Middlesex and one in Surrey not exceeding the manageable proportion of 600 beds, with an ample medical staff and a large proportion of attendants, would do more to keep down the burden of insanity, by curing the highest proportion of curable cases, than the most energetic and skilful use of the machinery at present employed. In these small curative establishments, it would be possible to make the treatment of each patient an object of especial care. The progress of the malady might be watched, the exhibition of appropriate remedies at specific periods would be possible, and the same clinical observation and research might be brought to bear on the work of cure which are now practicable only in "hospitals"—and a few private asylums—where the best results are undoubtedly obtained.

It cannot, surely, be necessary to adduce formal proof of the assertion that an institution of moderate dimensions is more likely to be useful as an hospital than one so large that, however well organized, the chief physician is unable to do more than bestow a passing glance on his patients. I have never heard the superior efficiency of a medium-sized establishment called in question. The chief objections urged have concerned administrative difficulties alleged to prevent the practical working of the scheme. It has, indeed, been contended that classification is easier in a large asylum than in a small one; but what those who advance the argument mean by classification is, as I have elsewhere remarked, rather a convenient shelving of cases than orderly combination for purposes of observation and cure. The experience of disciplinarians and educators of every school will attest the assertion that, where the object is to operate directly upon individual minds, the advantages of association—which consist mainly in overwhelming example and custom—cease to be apparent when the multitude thrown together is so vast as to render personal training impracticable. Supposed facilities of management growing out of the aggregation of cases concern only the question of convenience. It cannot even be pretended that they have the benefit of the patient in view.

Other objections raised relate to matters of cost. It is asserted that a small asylum cannot be conducted as cheaply as a large one. In so far as this allegation can apply to the case of an institution for five or six hundred patients, it is out of place in the present argument. My proposal is to make the hospital thoroughly efficient, the chronic house a much less elaborate and costly organization, and the wards for senile imbeciles no more expensive than humanity requires. The money saved by the reduction of many beds in the chief establishment, and the saving effected by transferring cases to the chronic house, would admit of a higher scale of payments in the hospital, with a corresponding increase of efficiency in the results gained.

For example, if the beds in two asylums cost on an average £30 a year, I would reduce the outlay in one house to £20 per bed, and expend the amount saved, upon the other, using it as an hospital. The number of beds in the latter being at the same time lessened, in proportion as the capacity of the cheaper house was increased, there would be a further saving; and economy might be carried to even greater lengths if the imbecile cases were removed from the chronic house to the workhouse, where the average charge would probably not exceed £16 each bed. It must be borne in mind that my proposal would not increase the total number of insane paupers under treatment, but, as I believe, in process of time, be found to shorten their cases and save many from becoming chronic. Meanwhile, the extra money I propose to expend on hospital beds would be saved on asylum beds, and a still further sum economized by providing for the senile and imbecile, in houses even less costly than those at Leavesden and Caterham, because for the care and comfort of such cases continuous medical attendance is certainly not necessary, or if it be, the expense may be reduced to a minimum by massing large numbers of such poor folk, with no deprivation of comfort, in a suitable and commodious establishment.

The asylum question narrows itself to one of method. The present system consists in attempting to meet the demand by simply multiplying the supply. I contend this practice is erroneous, and can never command entire success.

Justices may go on building new asylums until half the pauper population is, under some pretence, classed as insane and housed in public institutions. The alternative, and I believe the right course, is to deal with the disease in its individual manifestations, and to strive to shorten the average term of residence by preventing quiet, subdued, or exhausted cases from degenerating into dementia. Many forms of disease with mind symptoms, comprehended under the term "insanity," show a characteristic tendency to become confirmed and incurable. Medicine can do more to prevent this decadence than has yet been accomplished; but it must be so conditioned that an individualizing treatment may be possible, and easily carried out.

IV.—*ASYLUM CONSTRUCTION.*

So much has been written on this subject that he would be a bold man who hoped to say anything new. I have no such thought. It is only with the view of asking attention for two or three practical points I adventure this note on the subject.

As experience ripens it is manifest that committees erecting asylums are becoming aware that it is possible to obtain a building, of fair proportions and good working construction, at an outlay considerably less than that deemed necessary five and twenty, or even ten, years ago. It is also beginning to dawn on justices that the man who is about to use a tool must be the person most likely to know something of the way in which it should be fashioned, and is certainly entitled to a voice in the deliberations which precede and control the work of construction. It is not, unfortunately, the universal practice, even now, to select a superintendent early enough to secure the advantage of his advice and help in aid of the architect; but when this reasonable plan is adopted, economy and success usually reward the precaution.

However that may be, it is of the first moment to plan and arrange an asylum building so that it may be adapted, from time to time, for purposes of classification, without involving costly alterations. Much has been said for and against what has been designated the "ward system." The consideration

that an asylum, which is to play the part of an hospital for the cure of the insane, should not be wholly unlike an ordinary dwelling ought to have some weight. It is necessary that the change involved when an insane person is removed to a curative establishment should be strongly marked; but it cannot be forgotten that the change back again to small rooms and ordinary surroundings may if too disturbing undo the good which has been effected. In short, palatial asylums are, I think, a mistake, and, wholly apart from the question of working and treatment, to which allusion has been made elsewhere, apartments of moderate dimensions are better than imposing halls. The "corridor" system may be regarded as obsolete, but there is danger lest the "pavilion" plan should introduce new evils of its own.

The suggestion I wish to offer is, that an asylum should be constructed so as to give any superintendent an opportunity of classifying his patients as may seem best. No man should be tied down to a particular distribution by bonds of brick and mortar. Above all, it is necessary to make such preliminary arrangements as will enable the physician to give his patients the benefit of frequent and complete change, whenever he considers change desirable. Wards should not be too much alike in size or general conformation. Those low views of art which once led designers to revel in symmetry at the expense of beauty are happily dying out; but the official mind is sternly set against improvements. A vast frontage with "well-balanced" masses, the *beau ideal* of excellence in the absence of true feeling for constructional art, means reduplication of the same idea internally, until, except by numbers and signs—in the absence of a strong development of the topographical instinct—the inmate discovers no appreciable difference wherever he may be placed. This is a great drawback to management. It deprives the physician of one of his most powerful aids in treatment—change of scene.

It will be found convenient to build an asylum in blocks of irregular dimensions on different levels, when the site admits of this treatment, and to give the various apartments diversity of shape as well as size. The sleeping-rooms should be entirely separate from the day apartments, the two being

connected by cheerful and easy, as well as "safe," staircases. Instead of building up the wells, these should be intersected at intervals, if dangerously high, with sufficiently close iron network, so as to allow a central current of air to pass through the levels and not obstruct the reflected light.

With a view to facilitate any redistribution of patients which may be desirable, it will be well to substitute arches and pillars for solid walls in the construction of wards, or apartments on the same level, and to complete the separation with wooden or corrugated-iron partitions. The last-mentioned material judiciously introduced into asylums for the purpose named, would not only be cleanly and, suitably decorated, have a cheerful appearance, but, being easily removed, would facilitate that change in the relative proportion of single rooms and dormitories which from time to time becomes necessary. A spacious apartment, with a roof supported at intervals by arches and pillars, and provided with the necessary apparatus for fixing, might in a few hours be converted into a series of single rooms, or reduced in size, as the circumstances of the moment rendered expedient. It is obviously impossible to lay down any rule as to the proper relative number of associated and single rooms. This is a matter which must be left wholly to the determination of the superintendent, and I think he should have the power of making such changes as he may from time to time deem advisable, without the difficulty of needing to consult the committee or petition for alterations involving expenditure.

The old need or excuse for building asylums sound-proof no longer exists, and they are generally too heavy in construction. If day-space were gained by light iron and glass erections, in the nature of conservatories or "winter gardens," and sleeping-rooms provided of such dimensions as to accommodate four or six beds, in place of thirty, forty, or more, an asylum would be less costly and more homely, without any loss, possibly even a gain, of efficiency. The same rule applies to general provisions for the insane. A bath-room of moderate size adjacent to the sleeping-room is incomparably more convenient than an ambitious apparatus, to which patients must be conducted in parties, and where the process of bathing is converted into an operation of mag-

nitude generally requiring special measures for safety, and leading to many demoralizing and dirty practices, such as compelling a number of patients to undress in the same room, and washing two or more in the same water. Closet arrangements on a large scale are open to the like objection. The less the domestic method of construction is departed from in these matters the better. So, also, with regard to fireplaces, modes of heating, and ventilation—little, if anything, is saved at the outset, and much wasted in the long run, by the adoption of apparatus supposed to fulfil the requirements of a large establishment more cheaply than familiar appliances.

There is a radical fault at the base of the asylum system: and everything is made to conform to it. Uniformity is the too dominant idea. It is impossible to deal with minds in the mass. A body of men may be trained to act together like machinery, but the training and the result will be simply physical. In an institution designed for the cure of mental disease, where minds are to be recovered from derangement, and from which, it is hoped, they may be sent back to the world, the individuality of patients should on no account be sacrificed to uniformity. Individual treatment, personal obligations to self-control, variety in surrounding objects, diversity of clothing, of occupation—as far as possible—even of food, are essential, and ought to form component parts of the governing idea. The proof that uniformity is not the secret of economy has been wrought out by experience everywhere. The notion is only perpetuated by tradition, and such traditions as exist in connection with the care and treatment of the insane have but small claim to recognition, none to confidence.

V.—*ASYLUM ORGANIZATION.*

The keynote of the idea, the formative principle, the leading thought of organization in a curative establishment for the insane, should be supplied by the fact that the purpose for which the institution is erected and the means by which the object is to be attained are both medical. It follows that an asylum, in so far as it is desired to make it an

hospital for mental disease, must be medical in its character, and under medical control and administration. I have insisted on this indispensable condition of success in the reports and in previous pages, and there is nothing either to retract or qualify.

It should be clearly understood that the opinion so warmly and repeatedly expressed presupposes that the institution is intended to fulfil a higher purpose than the mere care, or safe custody, of lunatics. I will not go so far as to say that an establishment intended as a simple place of residence for the incurably insane ought to be under the supreme control of the medical officer attached. It is even doubtful whether an asylum devoted to the reception of "chronic cases" needs to be so constituted. Of course, every reasonable appliance likely to aid the few chronic cases who may in process of time regain their reason should be at the disposal of the physician, but it will probably suffice that he is permitted to carry out his treatment under liberal jurisdiction. Medical men are scarcely such good administrators as to render it desirable they should be burdened with the responsibilities of managerial work when such a location of authority is not indispensable.

The case of a curative establishment stands on a totally different footing. It is with æsthetic and moral agencies, not less than material, the physician, who includes psychology in his system of medicine, attempts to cure disease of the mind or bodily disease with mental symptoms. The whole range of appliances comprehended by the code of mental therapy must therefore be under his direct control. Attendants are his nurses; their methods of dealing with patients, their tempers, their very manner and attire, form part of the medical system by which the mind of the patient is to be impressed and his malady cured. Some cases require to be placed under the control of a firm, even austere guardian; others need the unobtrusive influences of a mild and sympathetic friend. In certain conditions of feeling, and with temperaments of a peculiar class, the presence of an official-looking attendant may be suggestive of the worst emotions, stir the most mischievous passions, and even strengthen and confirm hideous delusions. With others, an entirely different

susceptibility will exist. The same is true of all surrounding objects and circumstances. Insanity is so intractable a disease, and it is so important to cure it, that the means offered by these indirect influences cannot be spared. Unfortunately they are denied the superintendent who is not supreme.

Committees, with the best intentions, not unfrequently profess their willingness, and even anxiety, to meet the wishes of medical superintendents in every respect. This is practically a vain overture. Unless it be possible for the physician to employ what remedy he pleases, when he wants it, and to change the method as suddenly as a new indication arises, he is hampered and, in fact, helpless. A committee might as reasonably select the drugs of an ordinary hospital, lock them up in their own keeping, and dole them out at will, as reserve the right of appointing attendants and generally administering a curative establishment for the insane. It would not be difficult to prove that cases are neglected or maltreated at the critical moment, and pass beyond reach of remedy into the ranks of the permanently insane, because medical superintendents are intrusted with subordinate authority, can only suspend where they ought to dismiss, and are generally restricted in the provision and employment of remedies which, not being available at the precise moment when they are wanted in the case, are afterwards useless. It is easy to pour contempt on the plea for unlimited medical jurisdiction, but the authorities by which that plea has been supported are overwhelming, and the argument of experience is conclusive.

The medical superintendent of a curative establishment for the insane should be its chief and immediate director. Every subordinate officer, from the matron to the meanest official, ought to look to him as master. An appeal to the committee is fatal. Justices should hold their physician responsible for everything that concerns the institution under his control; but they will not be wise, and are shortsighted to wish, to weaken his influence by personal interposition. Nowhere is an undivided authority more essential than in an hospital for mad people. It is the only efficient form of government, and the most economical. In matters of finance the committee will find plenty of scope for the energy committees of

public institutions, dealing with public money, are bound to show.

I do not think, with here and there an exception, physicians are good at finance, and for "general purposes" an order of intellect which excels in science is not well adapted. It will therefore be expedient to provide an expert steward, who may act as accountant, and, taking his instructions from the medical superintendent from board day to board day, make periodic reports of his executive work to the committee. The steward is, in my judgment, the only subordinate official who should have any direct relations with the justices, and he should be carefully enjoined to work under the direction of the superintendent, as an officer of the committee appointed to do the bidding of the medical director, and act as his clerk. By an arrangement of this nature the control of money matters would rest with the committee, while the administration of domestic affairs was left in the hands of the medical superintendent. No irregularity or malpractice could, under such a distribution of powers, escape the knowledge of those who are responsible to quarter sessions for the integrity of the asylum as a whole.

It is, I think, important to give every resident physician having the chief control in the asylum a residence, sufficiently close to the wards, but detached. The mere fact of dwelling in an institution for the insane exercises a depressing, and too frequently a mischievous, influence on healthy minds; and when great responsibility is superadded to the sense of being surrounded by mad people, the effect is not unlikely to prove disastrous. It has been alleged that a resident physician will be more disposed to visit his wards frequently if he is "on the spot," than when the visit entails even a short walk in the open air. I have strong doubts on that point. If it be the fact, a covered passage may be made to connect the residence with the asylum; but the house occupied by the superintendent ought to be approached by a separate doorway, and—if it be necessary that an asylum should be encircled by walls and built like a prison—there ought to be a private path. The arrangements generally should be such as render the office of superintendent a permanent appointment. To secure this object, it must be possible for a gentleman to feel that he can,

without prejudice, bring up his family at home. That can seldom be the case when the house allotted for his use is part of the asylum, and approached by the public door. It is needless to discuss the topic in greater detail.

The general truth and force of the propositions advanced must, I think, be apparent to every one who will look at the situation from the medical standpoint. Having asserted that the superintendent should be supreme in every matter relating to administration; that he should employ all servants, and arrange the asylum as he deems best; there is nothing, according to my view, to add concerning organization which is not comprehended under the term "treatment," remembering always that I am now writing only of establishments for the *cure* of the insane.

VI.—"*WITH FRIENDS.*"

There is unquestionably a class of pauper lunatics, or persons so described, who might with safety, and even advantage, be placed in suitable keeping outside the walls of an asylum. The cases to which I allude have passed through a curative process and enjoyed the full benefit of treatment. Their maladies are of a class which, under proper restrictions, would not unfit them for residence in private families of their own order, and only a partial contribution from the public rates is needed for their support. One difficulty would be to single out from the multitude of patients those who might be so distributed: another, to find suitable families in which to place them. It is, I think, doubtful whether the experiment of boarding out lunatics has been properly tried in this country, with the most suitable or promising class of cases. Helpless, epileptic, paralyzed, or imbecile persons—in fact, those requiring attention, whether in the shape of control, protection, or nursing—ought not, unless under exceptional circumstances, to be placed with friends. In a rural district it is possible cottages could be found where a widow or a childless wife might be able and willing to take charge of a single case of the description indicated; but the system is not likely to work well in England, unless we could establish an English Gheel, with its

organized system of resident inspectors; and—as compared with the chronic asylum and infirmary system I have suggested—it is doubtful whether the organization it has sometimes been proposed to import, and naturalize in this country, would be economical.

The notion of distributing idiots in private families is, I think, wholly bad, and ought to be abandoned. Few individuals of the class, except the very worst specimens of amentia, are incapable of improvement by training, and it is of vital moment that all should be placed in institutions especially adapted for their tuition—not to be removed, as is the arbitrary practice under the Local Government Board system, at the age of sixteen, but only when either their faculties have been developed to fit them for self-supporting work in the world, or the conditions are so hopeless as to render transfer to the infirmary wards of a workhouse asylum or some suitable institution an advantage rather than an evil. Something may, however, be done to liberate the harmless, feeble-minded, and industrious, crotchety patients, who constitute no inconsiderable portion of the "quiet cases" in public institutions, from the thraldom of asylum life. Three objections will be urged to this proposal:—

1. These patients are wanted in the asylum to perform the needful service, and if they were withdrawn the expense must be increased by employing paid labour in their stead. My reply to this argument is simply that the number of such cases in nearly every county or borough asylum is in excess of the service required. I admit the plea that all the help obtainable from this source should be secured, in the interest of the ratepayers; but, after all the cleaning, washing, mending, and making needed for the asylum has been done, there is a residue of energy which ought to be usefully employed, and until the legislature can be brought to see that asylums should be houses for work, it is not only fair but desirable to relieve these establishments of those who, placed elsewhere, might become, at least partially, self-supporting.

2. It will be said the majority of those workable patients to whom I refer are quiet and tractable under asylum discipline, but cannot be trusted outside the area of that influence. I fancy this is an instance of truth with an enlarged applica-

tion. There are cases of recurrent disease, and persons more sour or uncertain-tempered than insane, whom it would be unsafe to let loose on society, although apparently well-conducted enough while subject to nominal control. Those are not the cases to which I allude. No medical superintendent, falling in with my views—if I may suppose the thing possible—would find serious difficulty in selecting patients from the population under his charge who might be placed out in positions of industry, if it were only possible to secure for them that continued guardianship which their mental weakness would require.

3. Exception will be taken to the recommendation that cases of the class indicated should be removed from an asylum, on the ground that they are better off where they are. I think the time has come when considerations of mere sentiment ought to be laid aside in dealing with the practical questions of lunacy. It was necessary, years ago, that an appeal should be made to every instinct, and prominently that of compassion, to achieve the emancipation of a pitiable class of sufferers from a system of neglect and cruelty little short of slavery —and slavery in its worst form, because the victims were not only unhelped, but incapable of ever taking measures for their own protection. That day has happily passed; and the moment has arrived when it may be prudent to bestow a reasonable amount of attention on the financial interests of the great community of bread-winners by whom pauper lunatics—many of them dependent only because they are certified as insane—have to be maintained. If there is a possibility of returning some, at least, of the multitude classed as "lunatics," or "of unsound mind," to the working population, measures with that view ought, in justice to patients and the public, to be taken.

It is not enough to say, "These people do very well where they are." That argument, pushed to its logical issue, would suggest the policy of retaining the criminal classes permanently in prison, with the view of keeping them out of mischief; or of locking up the multitude prone to give way to what weak minds call "temptation," to indulge habits of drink, and fall into other deplorable practices with disastrous results. If this maudlin sentiment is to sway the conduct of

public affairs, it will be difficult to predict where the craze may stop. Fanaticism and eccentricity would work wild havoc with the principle that what is objectionable may be freely repressed. While fully recognizing the need of due precaution in the discharge of seemingly "well-conducted" lunatics, I think it is necessary to remember, also, the danger of mistake on the side of hesitancy to return patients to the ranks of the self-supporting population as soon as that procedure may be reasonably safe.

The measure I suggest is briefly the following:—Establish in connection with every asylum a detached building, to which convalescent—or trustworthy, though not completely curable—patients may be transferred. Let them for a period reside in this establishment as lodgers, going to their daily work and returning to sleep. Give them a large amount of self-control, and let them contribute something towards the expenses of the institution out of their earnings. The recommendation has little claim to novelty; it has been substantially—though not precisely as I put it—advanced before. The proposal needs to be again urged on the consideration of those who are responsible for the lunacy system, and upon whom it devolves to advise the legislature.

I think the custom of boarding insane patients who require attention "with friends," is open to very serious abuses. The residence of such cases in workhouses, mixed with the general body of paupers, is equally unwise, and would expose a class which ought to be protected, to the worst forms of neglect and injury. Meanwhile, it is certainly possible, and seems necessary, to eliminate those who are capable of self-support—although still subjects of mental disease in some of its less obtrusive forms—from the mass of lunatics requiring treatment; and to place them under suitable surveillance in conditions where they may be able to labour for their own support, and perhaps that of their families. This, I think, might be accomplished in the manner already suggested.

ON TREATMENT.

VII.—*MEDICAL TREATMENT.*

UNDER this head should be included all that relates to the management of the lunatic, from the moment it is determined that he shall be removed to an asylum until his career as a patient ends, by discharge on recovery, removal, or death. Unfortunately the wide scope of this comprehensive summary is not always recognized. The breadth of the idea, taking in, as it does, all the conditions of life, and the relations of the lunatic with those around him, sane or insane, is not even generally perceived. We hear of a certain proportion of the insane in an asylum being under "medical treatment." The Commissioners foster the fallacy this phrase indicates. It is difficult to understand how men versed in the nature and management of mental disease can lend their authority to the perpetuation of so monstrous a misconception as that which characterizes the exhibition of pills and draughts, or the use of plasters and poultices, as "medical," when the ceaseless ministration of art to the mind diseased is described as mere management. Words come to possess practical importance when they are made the excuse for a policy mistaken in its nature and mischievous in its effects.

There is no more dangerous delusion in the range of lunacy than this notion that the care and treatment of the insane is not wholly medical. Again I must remind the reader that I am not thinking or writing about incurable insanity. In connection with that topic medicine has only a secondary interest—the concern which every humane science must have with the possible relief of suffering, wherever it may be found. The title I have chosen for this work embodies the thought which has inspired and controlled its pages—the

Care and Cure of the Insane. The care is bestowed with the purpose of cure : that is its object. To this end it is a means more or less effectual, but never swerving from the primary intent. Unless this is conceded, my argument falls to pieces. It is because "treatment" includes management and is always medical that I contend the medical superintendent ought to be supreme, and, from first to last, the care of lunatics should be conducted with a single eye to their recovery.

VIII.—*CERTIFYING.*

I think it will ultimately be found that a serious mistake has been made in requiring that a patient shall be certified insane before he is removed to an asylum. The purpose it was desired to effect by this precaution is obvious, and no one can entertain the shadow of a doubt as to the excellence of the intention. That a sane man or woman should be hurried off to a madhouse, and perhaps made insane by the procedure, or driven to madness by the treatment received at the asylum, was so intolerable that it is easy to see why any and every measure that could prevent this abuse must needs have appeared laudable. The requirement of certificates, given separately, after independent examination, by two medical men wholly unconnected, and neither having any interest in the fate of the patient, would seem a judicious precaution. The substitution of a magistrate's order for the certificate of one of these medical practitioners, in the case of a pauper, would appear to throw even greater protection over the possible victims of abuse and false imprisonment. When, however, it comes to be explained that the medical man signing the certificate may have never seen a lunatic, read a page of any work on insanity, heard a lecture on the subject, or been asked a question relating to it at any examination, the complexion of the case undergoes a change which is not reassuring.

When, now nearly twenty years ago, I began to write strongly on this subject in the public press, and took some pains to bring it under the notice of men in authority, I used nearly the words I have repeated above, and it was, unfortunately, possible to add that, except for the army medical

examination and the old East India Company's service, no knowledge of mental disease was either required or expected.

I remember well, in early life, signing a certificate, as casual adviser to a bench of magistrates, with nothing better than a College of Surgeons' diploma to back my opinion. I shall never forget the misgiving with which I entered a side room at one of the courts, "coached" by the relieving officer, or the anxiety with which I sought for indications, observed by myself, to support the plausible story narrated by the poor-law official. The only available symptom was "restlessness about the eyes," which was duly inscribed on the certificate paper, with a few equally meaningless phrases to fill up the rest of the blank. Probably the patient was insane, but I should be exceedingly sorry now to vouch for the fact. The magistrate was entirely guided by my judgment and the representations of the relieving officer! Could any state of matters be more deplorable? The condition is only a little better to-day. Not one in twenty of the average practitioners one meets is either qualified to form an opinion on a case of insanity, or justified in filling up a certificate. I was so impressed by the legal situation and my own incompetency, that I resolved to devote special attention to the subject, and that is how I come to be writing now.

It was many years ago when this happened, but the law still arms the mere surgeon with power to sign away the liberty of a fellow subject, and it requires that the judgment upon which the opinion is expressed in the certificate shall be formed at one interview, although the surgeon—if a prudent young man—would not venture to commit himself to a diagnosis of mumps or measles without taking some hours to think the question over, and probably, to refresh his memory by a quiet glance at somebody's *Practice of Physic.* On this malady, whereof he knows nothing—can know nothing, and in regard to which he may so readily make a mistake, perhaps worse than fatal—he is positively required to form and pronounce an irrevocable judgment offhand, without either time for thought or opportunity for reference.

Certificates of insanity are legal instruments of civil disability. They deprive the person named in them of the power to control himself and his property. They have proved worse

than a death-warrant to many a poor wretch. Possibly there are few abuses now, but the fact remains—the ordinary medical practitioner is incompetent to form the judgment required, and should not therefore be intrusted with the power to pronounce it. The suggestion I have to make is twofold; no certificate should be signed until after a patient has been placed under treatment, and then only by a public official acting in the name and by the authority of the Lord Chancellor under the power delegated to the Commissioners in Lunacy.

There are, I think, three fatal objections to the practice of signing certificates before placing a patient under treatment. Precious time is wasted; the circumstances are not propitious for a correct diagnosis; if an error is committed it is incomparably more serious, in a legal and social sense, than any wrong inflicted by mere false imprisonment. The early hours, almost minutes, of an attack of mental disease are often of the highest moment to the issue. While friends are faltering in their resolution to take so grave a step as placing a man or woman under certificate, the chances of cure are slipping away. The first effort should be to treat the case, not to talk and write about it. Imagine the consequences of waiting to obtain a parcel of legal documents before you began to treat a man for apoplexy. At such a moment it is impossible to introduce practitioners even singly, into the presence of a patient and expose him to their interrogatories without the danger of irritation, and perhaps permanent injury The condition of brain at the outset of an attack of acute mania is certainly not such as to warrant the risk of provocation or excitement. There is, moreover, as I have said, the peril of mistake. A person knowing he or she is supposed to be insane, is not likely to be free from symptoms which may easily be misconstrued as evidence of the malady the medical practitioner is expressly called in to certify.

It would be difficult to depict the situation more truthfully or forcibly than it was presented to the House of Commons by the late Mr. Wakley as far back as 1841, with this difference —that instead of a commission in lunacy being now necessary, the certificates of two totally inexperienced and, so far as insanity is concerned, unskilled medical practitioners, obtain-

able at the cost of a couple of guineas, will suffice for the perpetration of one of the greatest wrongs a man can inflict on his fellow, the irreparable crime of murder barely excepted. I quote from *Hansard* (3rd series, vol. 59, Aug.-Oct., 1841, p. 695), but reproduce the first person to recover the force of the argument as it fell from the lips of this clear thinker and bold speaker: "I entreat the House to observe the operation of the law as regards lunatics. Suppose I have a relation who is possessed of a large fortune—I perceive certain eccentricities in the conduct of that individual. From the great affection I have for that relative, and the still greater affection I have for his property, I cause a commission of lunacy to be issued out, and discovering him to be insane, place him in confinement. Then what motive of action is given, under the present system, to the person in whose charge the lunatic is placed? Why, it calls into operation the principle of selfishness common to human nature. The proprietor of the asylum will argue that he gets £400 a year for the charge of the gentleman so long as he remains under that roof; and if he recovered, then he (the proprietor) would lose that annual amount. Suppose an honourable gentleman were to go to a doctor, and say, 'My liver is diseased, and so long as it remains so I will give you £100 a year!' What motive of action in such case would be given to the doctor?"

It is, unhappily, as true now as when this picture was sketched, that the legislature "ought to set about to devise means of remedy for these things." The only effectual measure, as it appears to me, will be the substitution of a public, officially responsible, method of "certifying," for the privateer practice now legally recognized; together with such change in the relations of the insane with those who derive advantage from their infirmity as shall make the patient's recovery a benefit to his keeper and his permanent disability an occasion of loss and discredit.

The system I would substitute is to reserve, in connection with every public asylum, one or two single rooms of suitable dimensions, to which any patient, without reference to his station in life, might be removed on the first attack of madness. The onus of presenting the patient would rest upon the friends, to whom the ordeal of submitting their victim—in any case of

wrong-doing—to the scrutiny of the medical superintendent of a public institution would be infinitely more severe and deterrent than that of calling in two medical men, chosen specially, perhaps, for their inexperience. Give the medical superintendent the power—which is now vested in every relieving officer—to hold the patient in his custody for three days, during which he would, of course, take such measures as might be desirable for treatment. Immediately on the reception of such a case, let notice be sent by the friends, and the superintendent, to the Commissioners, under whose authority would issue an order to some examining officer to visit and certify. After this simple process was complete the patient could be transferred to a private house, or, if a pauper, removed to the wards. I do not assert that the scheme would not require modification in detail, but in principle I believe it not only offers many advantages over that now in force, but embodies the idea of a plan which must sooner or later be adopted in the interests of speedy cure and as a satisfactory guarantee against abuses. Perhaps the method of paying keepers of private asylums for the treatment of a case, instead of the time occupied in curing it, would give additional security.

The practice in regard to patients to be admitted into county or borough asylums is especially objectionable. They are first lodged in the workhouse to be made paupers, then taken before a magistrate—except in rare instances when the bodily condition of the patient is so bad that the justice must needs visit at the house. A medical man, generally the district poor-law officer, is called in to certify. Altogether three days may elapse before the case is placed under treatment, and the usage which the poor creature undergoes in the interval, particularly if there is much excitement, is terrible to contemplate. I do not mean to insinuate that there is either neglect or cruelty. Great injury may be inflicted on mind and body with the kindest intentions—and fully as much sympathy as any man or woman destined for a pauper lunatic asylum has, probably, a right to expect. It must be a wondrous relief to the sufferer, all unconscious as he appears, to be safely housed in the asylum, where, after the turmoil, kind and able treatment awaits him. It is in the last degree

irrational to allow a person attacked with mental disease to be removed to a workhouse, or intercepted by any machinery or institution, before being placed under the influence of measures adapted for his recovery.

IX.—*REMOVAL TO AN ASYLUM.*

There is not much to say on this topic, but there are two or three points on which I wish to speak strongly. It is generally supposed that any *ruse* is permissible to get a patient quietly inside the institution. This is a serious misconception. The chagrin which not unfrequently follows the discovery that he has been hoodwinked begets a feeling of revenge which may lay the foundation of much subsequent distrust. It is far better to preserve a rigorous silence, while showing sympathy by manner and management, than to practise deception. No doubt it is easier to lie than tell the truth under such circumstances, but a judicious reserve is incomparably more considerate. Sometimes it takes weeks or even months to establish the confidence essential to moral influence, after a patient has been cajoled into the asylum and discovers that he has been duped. Laymen cannot be expected to understand the importance of this precaution, but medical men who assume the right of signing certificates ought to be able to advise.

The recourse to mechanical restraints in removing a violent patient to an asylum is not so common as it used to be, and the system which has been adopted at many public asylums, of making a direct return to the clerk of the board of guardians as to the physical condition of each patient on admission, has done much to amend the condition of matters common not very long ago, and to which medical superintendents have so frequently and feelingly called attention. It would be exceedingly convenient if the practice which obtains in private asylums of sending trustworthy attendants for a patient could be extended to public institutions. It might be difficult to carry out the suggestion. Guardians would probably resist a charge for the service; and relieving officers, —judging from the state of merriment in which they not un-

frequently present themselves at asylums—enjoy the "outing" and, I regret to add, the "fun." Nevertheless it would, I repeat, be an improvement if attendants could be sent to bring patients direct from their homes—not the workhouses—to the asylum. Much needless excitement might be avoided and some pain of mind and body spared.

X.—*DIAGNOSIS.*

A diagnosis should be made immediately the patient is received into an asylum. The medical men upon whom this obligation is urged are, it must be remembered, or ought to be, practised observers. Their professional lives have been spent in the study of mental disease. Cases of every class—many, no doubt, typical—are around them; they can experience no difficulty, and will feel no hardship, in performing this clinical function. In hospitals for the insane, properly so called, the obvious duty is promptly discharged. In too many county and borough asylums, I fear, it is neglected; the requisite entry being made, and the case "written up" some days or even weeks afterwards. When the practice is thus irregular, patients lose the full benefit of treatment—instantly and intelligently directed for their relief. It is not enough to ascertain roughly whether a patient is violent or quiet, dangerous to himself or others, or reported harmless—which generally means treacherous, and therefore calls for special watchfulness. Unfortunately that is about all the diagnosis too many new patients get. They are then placed in a suitable part of the building, or—where the superintendent is especially careful—in the infirmary, and left to settle down. This "settling down" and "becoming at home" is too commonly a ruinous business, so far as the term of residence is concerned, if it does not affect the ultimate issue. When the scene is fresh and the circumstances strange, the dormant consciousness is generally to some extent aroused. If due advantage be taken of the opportunity, a remedy can sometimes be applied; if it is lost, the shortest way back to reason may possibly be closed.

Those who entertain the gloomy persuasion that insanity

is incurable will have little respect for my argument, and those who regard the malady as one that must run its course, and against which moral or mental influences are powerless, cannot be expected to attach the slightest importance to this remonstrance. I anticipate scant success with "medico-psychologists"; but there are men with whom the appeal to experience has still some claim to notice. Those who have closely watched cases of mental derangement, and studied the varying moods and degrees of self-consciousness exhibited by patients in the early stages of acute disease, will not need to be reminded that there are moments when a pause in the tumult of mania, or a break in the cloud of melancholy, seems to promise respite—when a gleam of intelligence for the instant lights up the stolid or preoccupied gaze. The reason, so to say, circles round its former abode awhile before it takes flight. It seems within sight and hailing distance, and there is still hope that it may be lured back. This is not a purely illusory conception.

The knowledge of mental disease gained by the management of large bodies of the insane is scarcely, perhaps, so precise as that acquired by the patient study of individual cases at closer quarters, and the general supervision of only two or three hundred patients. Medical superintendents, who have thus prepared themselves for the administration of a large asylum, will not either fail to attach due importance to personal influences, or doubt that the first few days of illness—when too often the patient is left to quiet down, or treated only for the physical symptoms associated with his mental state—constitute the period during which an individualizing treatment, in its broadest sense, is most needed and holds out the best promise of success. If it be withheld at this conjuncture, as generally happens in large asylums and where a routine practice prevails, there is little to be done in the way of remedy, until the end of the paroxysm—or mind fever—is reached in the natural process. Then, perhaps, comes a critical day, when either the acute disease may be extinguished, or the exhausted mind will sink into that condition of collapse which, if not vigorously and judiciously treated, must issue in mental death.

The course of mind disease follows closely the sequence

of events in a case of ordinary injury. There is the stage of febrile excitement quickly gliding into the inflammatory; afterwards comes the paralysis, or stiffening, of the organ affected, from disuse. You may sometimes arrest the mischief at the outset, before the morbid action is established. If that is impossible, or the treatment begins too late, little can be accomplished until the inflammatory state—with its *sequelæ*—subsides. Then arises the question whether the full use of the organ is to be regained, or the patient recover with a stiff joint or a helpless limb.

Nothing can be gained by pursuing the subject further. If the importance of determining the precise nature of the mental injury, or the bodily lesion with mind symptoms, at the outset—just as the surgeon makes it his business to discriminate between a fracture and a dislocation before he applies the first splints and bandages—be not recognized, it is vain to press the argument. I will only, at the risk of appearing to dogmatize, express my strong conviction that a practice which ignores the need of this instant and individualizing treatment, and contents itself with a general classification of cases on admission, putting off the diagnosis and postponing all but the rudest physical measures for relief until after excitement has subsided, is the fruit of thinking only of a noun of multitude when dealing with "the insane."

XI.—*CLASSIFICATION.*

This is an evil when it is made to do duty for diagnosis. The two processes are commonly confounded. When a new-comer has been referred to a class of patients—generally an artificial group of inmates thrown together for managerial purposes rather than a scientific combination of morbid phenomena—the discrimination is supposed to be complete. Any more which may be made out is credited to the acumen of clinical observation, and set down in the case-book reverently, with the respect due to exceptional industry.

The classification suggested by convenience is the bane of asylum practice, and one of the greatest obstacles to progress. Diagnosis deals with the individual; classification

concerns the crowd. The moment a case is put into a class, so far as any scientific consideration may be involved, it is lost. The patient becomes in fact, if not in formal designation, as much Number One, or Number One Hundred, as the convict condemned to penal servitude, and, like the slave of punishment, he seldom afterwards attracts attention unless by giving trouble to those who pull the puppet-strings of his automatic life. In a word, the classification generally adopted is a system of shelving, by which work that cannot be done in detail, because the task is too vast, is, in a fashion, done in the mass. It would be more candid to confess that it is not done at all.

Classification in the scientific, and only worthy, sense I take to be a process like that by which the natural order, the family, and the class of an organism is determined. It is not to be accomplished by singling out a few characteristics, such as a propensity to commit suicide, a stupid downcast look, and obstinate silence; a crack in the voice, unequal pupils, or an incipient limp; inability to control, or inattention to, the calls of nature. These are symptoms which may each and all occur in more than one group of diseases, and invariably require to be traced home to their causes, and collated with indications less noticeable at a glance but incomparably more important. I shall be reminded that patients are classed as "suicidal" or "refractory," "melancholic" or "demented," "epileptic" or "maniacal," for purposes—for example, safety, order, cleanliness, protection, and the like—which, while necessary in themselves, have no immediate relation to treatment. That is precisely the state of matters of which I complain. My warm contention is that treatment should begin the moment a patient enters an asylum, if not before; and nothing that affects his mode of life, his surroundings, his sleep, exercise, food, clothing, occupation, in short, any part of the discipline to which he is subjected, ought to be excluded from the scheme of cure.

Of course this will be characterized as "utopian," and set down as a proof of the "unpractical" nature of the writer's views of lunacy and its requirements. I have heard, and read, the remark not unfrequently during this inquiry, and it has so far affected me that I have examined the grounds of the

opinions expressed, afresh and more closely—as every man should revert to the bases of his argument when the inference he dares to suggest is called in question. I am only strengthened in the persuasion that the received methods of asylum management, so far as treatment is concerned, rest on an entire misconception of the nature and indications of mental disease, the possibilities of remedy, and the aids most likely to further and expedite recovery. Moreover, I am convinced that a classification having for its object, not the cure of the patient, but the convenience of those who are burdened with his care, lies at the root of a defective system of management, which nothing short of reconstruction on the basis of case, instead of class, treatment can amend.

XII.—*SLEEP.*

Sleep, when the intellectual faculties are deranged or the mind is diseased, may be justly regarded as one of the most important functions to be performed by the organism—I am afraid to say the brain, because no one knows precisely where the seat of this phenomenon is located, or how it is produced. Even when the state of "falling asleep" is passive rather than active, it must be preceded, or accompanied, by an inhibitory impulse controlling the circulatory organs, and may therefore, for practical purposes, be considered as a function to be performed. With some persons "going to sleep" is a voluntary act.

Inability to sleep is a distressing, and not unfrequently a premonitory, symptom of mental disease. Slumber is anticipated as the harbinger of improvement. This is the popular expectation, and it would seem that the profession shares the conceit without taking the trouble to discriminate between the bare phenomenon and the diverse causes from which it may spring. On no hypothesis, except that the effect is desired instead of the cause, is it possible to explain the strange circumstance that sleep induced by drugs is deemed worth the pains and risk of producing. There is, indeed, the theory of conservation of strength. It is supposed that the patient must sink if he cannot sleep; and with a view to ward

off impending exhaustion, the physician steps in with his hypnotic and places the patient in a condition simulating sleep. The physical excitement being suspended, the strength of the organism is supposed to be spared, and it is even alleged that a recuperative process may be set up in the interval gained by the recourse to drugs.

I have stated the theory because I think it needs reconsideration throughout. I believe the notion that exhaustion naturally induced in the early days of mania must needs be injurious is unfounded. I am careful to say naturally induced, because the exhaustion following excitement provoked by restraints or ill-treatment is a totally different condition, more nearly approaching collapse. So far from sleep produced by drugs being an advantage, I am strongly impressed with the conviction that it generally interrupts the natural course of the malady—postpones, often prevents the normal crisis, and converts what ought to have been a short paroxysmal malady into a lingering indeterminate disease. The exhaustion produced by an acute attack of mania in a case properly supported by food, neither over-stimulated nor allowed to grow faint, and in no way exaggerated by opposition, will commonly occur somewhat suddenly. If properly managed, this exhaustion is not necessarily fraught with peril to life or intellect. If nutriment of suitable quality and quantity be promptly supplied, natural sleep ensues, and under favourable circumstances the patient may awake relieved. Whether the benefit gained will be permanent must depend upon the character of the disease ; the all-important nature of the cause, whether operating continuously or having ceased after the first explosion ; the violence of the original morbid impulse, whether so great as to produce a succession of paroxysms, like the ricochetting of a ball propelled with great initial force, or possessing a momentum destined to expire in a single outburst. The issue will also be affected by the treatment. Occasionally the measures taken to arrest may prolong the disease, even changing its type by breaking the rhythm. It is not alone "circular insanity" that moves in circles. Scientific observation has discovered periodicity in most forms of physical disease, and the morbid actions of mind are governed by the same laws of order and sequence.

Nevertheless sleep is a great composer of morbid mental excitement. When induced by the operation of natural causes, neither poisoned by drugs nor brought about by processes that stupefy rather than tranquilize, it is seldom without a beneficent influence in cases of acute mania. It is, therefore, of the highest moment to surround the patient with conditions favourable to repose. The measures taken to establish a state in which sleep is probable must be both material and mental. It is vain to provide a quiet apartment and a comfortable bed, to shut out light, exclude obvious causes of irritation, and expect a patient to sleep, when the mind is the scene of restless turmoil, and perhaps still further distressed by the means employed for its composure. This condition of matters, I believe, often obtains when a noisy patient is placed in seclusion with the hope that ceaseless, wearing excitement will end in sleep. Unless some direct attempt be made to reduce the mental disquietude, the process through which a mind harassed by a sense of grievance—possibly finding fresh cause of offence in the imprisonment inflicted—must pass, is not only circuitous but beset by perils. The practice of removing a turbulent patient forcibly from a ward, and locking him up alone, even "in his own bedroom," with the expectation that sleep will end the turmoil, is no doubt an improvement on the old system of throwing him on a bed of straw, clapping handcuffs on his wrists, and fixing him with a leg-iron to the wall or the bedstead; but it is not *treatment*, and the sleep that follows, if temporary respite supervenes, is neither natural, refreshing, nor recuperative.

The practice of allowing children to cry themselves to sleep has happily died out. It is at length seen to be of more than passing moment in what mood a little mind enters the realm of dreams. It may, possibly, hereafter dawn on the intelligence of medical psychologists that the morbid mind is even more susceptible of injurious influences than an organism imperfectly developed, no doubt, but not weakened by disease. "To sleep! perchance to dream!" Dreams are madness. The mind that dreams while it wakes is mad. Insanity is a prolonged sleep-waking, and possibly the brain of the lunatic is permanently in the same condition as that of the sleeper who dreams—half benumbed. If the whole organ can be made to

slumber, it may wake whole. This occasionally happens when, after a profound repose, the subject of acute disease returns to normal consciousness on being aroused. It is a perilous practice to send the maniac to his bed with a new cause of disquietude, a fresh toy for the elf that haunts, another instrument of torture for the fiend that torments, him. The wise physician, with some insight and knowledge of mental nature, will try every expedient before he condemns the mind convulsed by passion, fired with frenzy, to a solitude peopled with its own morbid imaginings. By removal to another ward, away from the cause of irritation, by the introduction of some new object of interest, by the timely administration of food, he will strive to restore quiet *before* the patient is left to sleep.

The supply of food is one of the most powerful and natural producers of sleep. Give an enraged animal a good meal, and he will generally forget his quarrel and fall asleep. Medical superintendents, whose practice is shaped on the lines of experience rather than theory, can scarcely fail to have proved the value of food as a soporific. Many a furious paroxysm might be avoided by a full meal of unstimulating and easily digestible material. Next in order of importance is a reasonable amount of consideration for the idiosyncrasies of personal temperament. To some, darkness is terrible; with others, light is unsuitable. There are many apparently trivial matters, little enough in themselves, but of high moment to the patient. Where one inflexible rule controls the practice of an asylum, these details must of course be disregarded; but by striving to make wholly dissimilar minds conform to the same mould, the possibilities of recovery are minimized, and time and money lost. Take a hundred sane persons, send them to bed at the same hour and under precisely similar circumstances, and ask next morning how many have slept well and feel refreshed. Insanity does not utterly extinguish self-consciousness or level all likes and dislikes. One of the first necessities of an asylum is order, but there is order in nature without dull uniformity. The sagacity of the practical psychologist will be displayed in embodying that measure of diversity in his administrative idea which may be essential to an individualizing treatment and conducive to success.

Whether a patient should sleep alone in a single room or with others in a dormitory, the extent to which he ought to be protected from his own propensities and the measures necessary to insure safety without preventing or disturbing repose, the hour, and the manner of his awakening, are all matters of importance which should be determined on the basis of individual needs. It would not be an impossible task—even in a public asylum, with a sufficient staff of trained and attentive servants—to adjust these lesser details in the manner required by a personal policy. The surgeon in charge of a large number of wounded men finds no insuperable difficulty in teaching his dressers to deal directly with cases demanding widely different measures and appliances. The attendants to whose care the insane are confided should be as expert in their way as average hospital orderlies. It has already been insisted that no medical superintendent ought to be placed in charge of an establishment larger than he can effectually supervise. I lay stress on these matters in connection with the subject of sleep, because I believe the trouble-saving routine practice of sending everybody to rest at a particular hour, and requiring all to rise together in the morning, rousing the sleepy with scant care or sympathy, hurrying them through the process of washing, souring their tempers for the day, and returning them surly and sleepless to bed at night, is the cause of more mischief to weak minds, and in the long run entails more distress to patients and disappointment to medical superintendents, than almost any other of the mistakes which impair the usefulness of asylum control.

XIII.—*RESTRAINTS.*

Restraints are indispensable; without their diligent and unrelenting use the care of the insane could not be conducted with safety or even moderate success, and their cure would be impossible. If recovery happened it would be in spite, not in consequence, of the treatment. The "non-restraint" system is a misnomer. If it were what the phrase implies, it would be worse than impracticable—a delusion and a snare. Nevertheless, I believe such a system is growing up amongst

us and flourishes north of the Tweed, where we find asylum doors without locks, grounds without walls or fences, a loose system of *parole* without the power of truth or self-government on the part of the patient—I beg pardon ; there can be no patients, because, in some instances at least, they have abolished the "doctor!" I do not like to express an opinion seemingly adverse to the endeavour to substitute moral for physical restraints, but it is incumbent on any one hoping even for a hearing on this important subject, to characterize a practice like that pursued in Scotland as unreasonable.

Restraints will always be necessary, and they must be effectual. The sum of my contention is that they need but seldom be mechanical—scarcely more frequently than such contrivances are required to aid the self-controlling effort of the sane—and, as a rule from which it is barely possible to conceive of any intelligent departure, they should not be employed either to oppose, prevent, or subdue violence. It is the meeting of physical strength with strength either material or muscular, passive or active, against which I have said so many hard things in these pages and elsewhere.

It is interesting and curious to notice how books, written by men strong in the persuasion that physical restraint of some kind must occasionally be employed, abound with cases in which the greatest difficulties have been surmounted and the most critical emergencies met by a clever recourse to methods of control wholly mental, and in the highest and best sense triumphant. Instead of springing on a man like a panther on his prey, pinning him by brute force, and arousing the savagery of his debased, because disabled, nature, or destroying the last vestige of that self-respect which supplies the only enduring motive of good conduct, a timely diversion has been attempted or a powerful appeal made to the faculty of self-control, approaching it from a new direction. It is strange the brilliant success of these expedients has not convinced really able and humane physicians that what has been done occasionally "on the spur of the moment" might be reduced to practice and done habitually. Too frequently the victory won by sagacity has been thrown away by the folly of following up a moral triumph with physical coercion, and

rewarding a concession to reason by irrational punishment. Nevertheless the fact remains, experience has proved moral influences sufficient and supreme.

If physical force is opposed with physical force, whatever be the nature of the powers engaged, nothing can be gained by the struggle. When an insane patient suddenly becomes excited, and threatens or even does violence, I do not conceive the obligation to think of cure, and cure only, is suspended. Let it be remembered we are speaking of curable cases. I cannot admit that "the immediate object must be to secure the patient." When that intent is uppermost in the minds of those around, they cease to be medical agents, and degenerate into mere keepers. At the risk of being denounced as unpractical still more strongly than heretofore, I cannot hesitate to reassert my belief that it is not only proper but possible, in such an emergency, to obtain the mastery without recourse to physical coercion. It is of little avail to seize a patient after he has done mischief; the explosion has taken place, and the paroxysm will generally subside. I am not speaking of cases in which violent patients possess themselves of weapons. Those are instances of carelessness on the part of attendants, for which they should be punished: not always by dismissal; a man or woman who has failed and sincerely regrets the fault may be more trustworthy in the future than one who has not had so painful an experience. Patients should never be punished. Cases of the class just mentioned are wrong all through, and it is not reasonable to expect moral influences can be suddenly employed to set matters right. You cannot use steam for purposes of work without an engine and appropriate machinery. The system of moral influences must be established before their power can be felt, but when that system is established it is scarcely ever—I might almost say never—necessary to call in physical restraint to the aid of mental and moral forces.

Among physical restraints must be classed "seclusion." If there is no restraint in the procedure, the patient is neither legally nor in fact secluded. No one, I imagine, doubts the expediency of inducing a patient to retire for a while under circumstances of excitement, when solitude is not likely to aggravate the sense of grievance. Retirement is a widely

different matter from seclusion, as different as taking walking exercise and being put on the treadmill. Locking a man or woman up in an apartment alone, whether it be a padded chamber or a bedroom, is imprisonment, and imprisonment is restraint. I doubt that such a mode of repressing or exhausting excitement is reasonable or free from danger. I have already spoken of the peril of placing a distracted mind alone with the demon of its own self-consciousness. You are shutting a poor creature up with a spectre, leaving the weakened and dazed intellect a prey to its own delusions. That is a bitter wrong to inflict on any being of human sensibilities, however blunted. There will presently be an opportunity to speak of the alternative, the substitution of another scene for that with which the turmoil is associated—by change.

In the minute of the Commissioners in Lunacy on their inspection of Colney Hatch Asylum, 30th March, 1857, I find the following :—"We avail ourselves of this occasion to record our opinion that, as a means of allaying maniacal excitement, active and extended exercise is preferable on every account to seclusion." Experience abundantly proves the truth of this judgment. For the moment, let me only insist that the restraint of a locked door is a needless recourse, and a new source of irritation in the very cases where it appears to be useful. When the mind is impressed by that means, it is susceptible of better and more remedial influences by other methods of treatment. Where seclusion is simply adopted to confine—as a wild beast may be caged—there must be something wrong in the system of management, or the experience of Pinel, of Gardner-Hill, Charlesworth, Conolly, and a host of successful practitioners has belied the testimony of fact, and my own senses have strangely deceived me.

What I have to urge on the subject of restraints may be compressed into a sentence. When the force exerted is wholly physical, restraint is unnecessary and mischievous, however applied ; when it is mental, the measure is only useful in so far as it incites the patient to *self*-control. For this last object it is indispensable, but I fear it is seldom employed with the purpose indicated or, so applied as to be both physically safe and morally effectual.

XIV.—*CHANGE.*

The tonic influence of change is clearly recognized. The mental action of the remedy is as generally perceived, although possibly not so well understood, as the physical. When a patient, recovering from any ordinary disease, has reached the stage at which there commonly occurs a dead point in the progress ; when something which no drug can supply is needed to revive the normal functions and processes of life—to re-establish, as it were, the rhythm of health among the disordered organs—the physician prescribes change. It is strange the value of this potent restorative has not obtained adequate recognition in the therapy of mental disease.

Mere change of scene has, indeed, long been a hackneyed prescription for the various forms of incipient melancholia and such nondescript derangements as have acquired the designations, "nervousness," "megrims," or "hypochondriasis." Even that novelty of the nineteenth century, "overwork," has been treated with a scamper over the continent, mountaineering, and the like expedients for wasting precious time and spending precious strength, every moment and foot-pound of which may possibly be required to carry the patient over the psycho-physiological difficulty. A rapid panorama of objects presented to the eye, such stimulus as travel supplies to the cerebral organism through the medium of the nervous and muscular systems, together with the corrective influence of work on the functions of nutrition, do not, however, realize my notion of the value of change in treating actual insanity.

I have already insisted on the necessity of complete change in the locality and associations of a case of lunacy as the preliminary condition of treatment. The mind must be detached from the scene and accessories of the attack before the malady can be successfully approached with appropriate remedies. We know how close is the connection subsisting between operations of the mind and the surroundings, even the posture, of the body. By returning to a locality, and again taking up the position occupied when a particular thought passed through the mind, it may generally be recalled, although seemingly forgotten. Conversely, to get rid of the mental state we must change the circumstances, the occupation,

and the habits of a patient. I would go so far as to urge that, for a time at least, the convalescent should not be allowed to work at his own trade, or follow the bent of his habitual inclinations. The mind must, so to say, be taken out of itself—separated from the accessories which have grown up around, and perhaps entangled and crushed it, to be put right.

I think what is done at the outset should be repeated frequently in the course of treatment. Instead of attempting to curb or repress the turbulent passions of a lunatic, male or female, it is better to lift the mind again and again out of the circumstances in which excitement has been reproduced. In the great majority of instances a paroxysm of turbulence will quickly subside if the patient be transferred to another ward. This method of treating the violence of lunatics is incomparably more considerate, and will be attended with greater success, than the recourse to seclusion. Instead of throwing the mind back on its own morbid reflections, you awaken a new train of thoughts, and the old one, with its causes of irritation and its distresses, is superseded. Asylums ought, as I have said, to be so constructed and arranged as to render frequent change possible; and instead of wards being so much alike that little or no difference is perceptible on passing from one to the other, they should be divided and decorated, and—in new buildings—planned, so as to render the change complete and even startling. It is easy to pour ridicule on this idea, but those who do so, either from inexperience or having a mere routine interest in the treatment of mental disease, sacrifice a potent agent of good. I believe the observation of careful practitioners among the insane will approve this remark. Such physicians must remember instances of complete pacification brought about by cheerfully, not angrily, removing an excited patient to another ward, and providing the mind with fresh materials for thought and reflection.

It would scarcely be stating the case too strongly to assert that in nine out of every ten instances of turbulence which appear to call for, and are treated with, seclusion, the cause is removable. Either the attendant or some fellow-patient has irritated the offender. In the tenth case, I will venture to affirm, the outbreak is the fruit of weariness, and exhaustion of the weak faculty of self-control, produced by keeping a

person morbidly sensitive in the same ward, with the same surroundings, too continuously. We hear a great deal of patients attaching themselves to a particular attendant, and being distressed at the idea of removal. I am sceptical as to the "attachment"; but if the regard is real, it would be intensified rather than weakened by allowing the patient to pass a few days in another ward occasionally, and thus trying the effect of new associations as a remedy. So employed, change will, I believe, be found to render seclusion almost, if not altogether, unnecessary; and the subsidence of excitement, brought about without the sense of being punished, will of itself constitute a mental triumph in curable cases, marking a step on the way to recovery.

XV.—*FOOD.*

The supply of sufficient and suitable food to patients suffering from disease with mind symptoms is the first condition of success in treatment. The blood has more to do with mental phenomena than has the physical structure of the brain. A deficiency of nutritive elements in that fluid affects the functions of the mental organ before its constituent state undergoes appreciable change. Marshall Hall illustrated this truth by what he appropriately termed the "temper disease," a transient form of which affection attacks many persons when kept waiting for food beyond the accustomed time. The blood being deprived of its nutrient supply, the equilibrium of consumption and repair is disturbed, and something equivalent to distress in the brain is experienced. The machinery of the mind labours, and excitement supervenes upon exhaustion. The mental state at the moment is a faint and incomplete forecast of the condition which would be established if, instead of simple delay, actual starvation occurred, and the blood no longer contained the elements on which body and mind both feed. The delirium which precedes death from inanition is probably caused by the re-absorption of excrementitious materials present in the circulating fluid, which would not be taken up if nutritive elements could be found.

Both as regards quantity and quality, the food taken by lunatics in asylums is, I am convinced, below the standard

of healthy supply. I do not like to assert that the allowance made to pauper patients is insufficient, because the diet lists in force at the metropolitan licensed houses,—where, I am informed, "all classes of patients have as much as they choose to take,"—are not appreciably better than those in the county and borough asylums, while the dietary in the hospitals, although richer and more liberal than at the county establishments, fails to reach the level of Dr. Lyon Playfair's standard for "Moderate Exercise," which does not seem to be in excess of the demand for average lunatics. It is, however, abundantly evident that the condition of matters cannot satisfy a judgment formed without prejudice, and I feel bound to urge that, looking to the ascertained facts in regard to nutrition, and the value of a full supply of food in the treatment of insanity, the experiment of increase ought to be made. No consideration of supposed economy should induce justices and committees of asylums and hospitals generally to withhold the means of making this trial. If the poor can be cured more rapidly than now—even though in certain cases death should be averted by the more liberal provision, and blighted lives continue longer a burden—the net result will recoup the outlay.

There is no room to doubt that a full diet expedites recovery in almost all forms of the disease. It does not, however, follow that the elements of food should be highly nitrogenous. I believe fish might with advantage occupy a more prominent position in the list than it does at present. It is impossible not to feel that many recent speculations as to the mode in which a diet in which fish is largely represented acts usefully, have been calculated to damage the credit of this article; but without endorsing the nonsensical pretensions set up in its behalf, no practical man can question its value as food for insane patients, and I think most superintendents will agree that one or even two fish days a week would be an improvement, both as giving greater variety, and introducing a dish generally appreciated, if properly cooked and served. In many of the large establishments fish is at present freely employed as an alternative; my remarks apply to its use as a regular element of the diet list for all patients, except here and there an individual who may regard it with dislike.

Stimulants are, I am convinced, necessary, and I trust the "craze" in favour of teetotalism, which has apparently, for the nonce, warped so many otherwise sound and calm judgments, will not be introduced into asylum management. Frankly, I do not believe drink plays the part it is popularly alleged to play in the causation of insanity. A tendency to the abuse of intoxicating liquors is often a symptom of incipient or developed disease, but it is very seldom the cause. In proof of this assertion I appeal to the fact that few practitioners, even of many years' experience and with extended opportunities of observation, can recollect half a dozen cases in which habits of intemperance have landed a patient in an asylum. The drunkard, or, which is worse, the habitual drinker who seldom becomes inebriated, will die of kidney or liver disease, phthisis, or delirium tremens; but, the wild statements of platform physicians and surgeons notwithstanding, the hard or habitual drinker scarcely ever becomes insane —not nearly so frequently as the man who, working with his brain, mistakes the power of explosive effort for continuous exertion, and, over-feeding with nitrogenous food, lives on his reserve and exhausts not only his resources, but the faculty of recuperative nutrition itself.

A too highly animalized diet is not less mischievous in its effects than an excessive supply of alcohol. If men and women, particularly the former, and especially those who labour with mental powers, would reduce the flesh element in their diet list, and replace the amount by fish, the tendency to brain-breaking and "collapse" would be diminished, at least one factor in the production of insanity would be eliminated, and a peculiarly painful class of cases less numerous than now. The multitude of underfed and overworked paupers crowded into public asylums need a rich and full diet, with rest; the overfed and underworked persons who form the bulk of the "private patients" in "licensed houses," especially the multitude of lazy and languishing young females, need a moderate diet, and steady continuous work of some useful kind for their relief. The distressing and humiliating class of cases attributed to "overwork," which might more suitably be ascribed to hurried or unmethodical effort, are for the most part improperly nourished, although

excessively supplied. Their position is incomparably more serious than that of the poor—who suffer chiefly from want and weariness—because the function of nutrition is itself disordered, and possibly the faculty of healthy restoration destroyed. Food is a subject of higher and more practical concern than drink ; and when the fashion of the hour has swept by, and common sense again asserts its sway, we may, perhaps, hope this all-important topic will engage the attention it deserves, and receive that scientific scrutiny without which the crude facts at present collected can be of little practical value, and any attempt to draw precise deductions must be vain. Meanwhile, in the suggestion that a more liberal and varied diet should be provided for the inmates of asylums and hospitals, there can be no hesitancy, and the recommendation must be pressed on the consideration of all concerned.

XVI.—*CLOTHING.*

The clothing of the insane in public asylums is, unfortunately, a matter that cannot be discussed on its independent merits as an element of treatment ; which ought to be possible. There is the economic aspect of the question ; and although committees are generally disposed to provide liberally, they will be biased by conventional notions of cheapness and propriety. Medical superintendents are, I fear, even more obstructive than the financial authorities of asylums. Partly from an exaggerated notion of the value of what they are pleased to call "discipline," and in some degree influenced by fear of the Commissioners, who are much too ready to set down any omission in the matter of dress to neglect or parsimony, they insist on patients wearing a regulation set of articles, which often constitutes a source of great annoyance. It is by no means uncommon to see patients sulking or writhing under the irritation of an abhorred necktie or boots, which not only make their lives miserable, but produce excitement, and aggravate—sometimes, perhaps, confirm—the disease.

Wherein is the triumph of making a dog wear a collar, after worrying his life and spoiling his temper ? There are other ways of asserting the majesty of the sane mind than

the enforcement of conventional methods of clothing the bodies of the insane. If the task of re-seating the intelligent will is to be complicated, by coupling therewith the reconstruction of every mind to a common pattern ; if idiosyncrasies, harmless in themselves, are to be crushed out by the methodical discipline of an asylum, I confess the enterprise strikes me as vast rather than noble. There is, doubtless, a kind of carelessness in dressing which needs to be corrected, because it indicates a wayward or listless habit of mind, injurious to the patient's well-being ; but the cure of this evil is a matter quite apart from the attempt to make men and women wear clothing which is persistently distasteful to them. A collar awry, a necktie with the bow behind, may have some mischievous connection with the notion of a twisted head—in which case, however, I am not sure it is wise to attack the delusion so directly as the enforcement of an ordinary mode of dressing would imply. The same peculiarities springing from mere neglect ought to be remedied. Meanwhile a steady objection to wear collar or necktie, at all, may not be a piece of madness ; and if the medical superintendent will take the trouble to study his patient, and allow the disuse of the annoying article, on condition that a decent appearance can be kept up without it, I think he will not only perform an act of kindness, but remove a cause of irritation from which worse than inconvenient consequences may occasionally arise.

Considerable differences of feeling as regards clothes may exist within the bounds of sanity. Some individuals like the sensation of being fully attired ; they are comforted by the consciousness of being properly clothed from head to foot. The presence of bands and the weight of materials are not abhorrent to them. Others cannot endure to be reminded of their garb. A high collar, a tight necktie, a stiff coat, hard or heavy boots, even a pair of gloves, will produce a fever of excitement and an affection which is the same in kind—though arising from a peripheral instead of a centric cause—as St. Vitus's dance. To a few persons the tickling of flannel may be refreshing ; to most it is insupportable. Some revel in linen ; others are "chilled to the bone" by contact even with calico. With certain conditions of sensibility, heat is a

necessity; for others, cold, even a current of cool air laving the skin, will be a ministration of comfort essential to health. Now, as I have said before, take a hundred average mortals from the sane world and enforce uniformity. Will they be happy or even tractable? The soldier submits to be compressed into regulation attire and accoutrements, but he is not the happier for the infliction; and men who enlist are not commonly made of the highly sensitive material which resents what is not agreeable. I believe the attempt to dress lunatics alike, in respect either to the number, the weight, or the pattern of the articles which clothe them, is a mistake; and although it is easy to see why the Commissioners enforce a sufficiency of clothing, I think they err in compelling, or enjoining, committees and superintendents to impose uniformity.

Nor can the æsthetics of dress be disregarded in a system of treatment which strives to press every agency—capable of affecting the mind through the special and general sensibilities—into its service. I have expressed a strong opinion adverse to the adoption of an asylum uniform, on the ground of the seeming provision for long residence. This is a point for which I would again ask the reader's careful consideration. Something has also been said of the moral influence of decent clothing "to restrain" patients—I use that phrase in what I believe to be its true sense in connection with lunacy—from the wilful or wanton destruction of their clothing. It remains only to add that the effect of a sombre garb, without variety, colour, or ornament, is as depressing in an asylum as it would be elsewhere. Some disordered minds are, no doubt, more susceptible of such influences than others; but even the stolid will gaze with interest at a bright and diversified scene. I believe the provision of pleasing and appropriate clothing for patients and attendants is an obvious piece of policy in asylum management unaccountably neglected. I have heard thoughtful medical superintendents say they do not choose to dress as doctors—"It is not well for the patients." Is it well for patients to be themselves dressed, or to be surrounded by persons attired, like the victims of penal servitude, or poor crazy paupers condemned to a life of unpleasantness and gloom? It would not be more costly, in the long run, to deal with clothing as a part of treatment—which it must be for good or

evil, whether the effect be intended or unnoticed—and to allow considerations of mental expediency weight in the choice of dress, than to pursue the system at present in force. In respect to this, as to many other matters in lunacy, it needs only the will: the way stands wide open.

XVII.—*EXERCISE, OCCUPATION, AND AMUSEMENT.*

So many occasions have arisen for remark on the cognate and equally important topics of exercise, occupation, and amusement, that little more need be said. It is chiefly because I am anxious once more to urge that these matters should always be considered and employed as treatment—never in any other way—that I have set down the subject for formal notice here. Exercise should bear a definite relation to individual strength; and as the faculties which enable a sane person to adapt his exertions to his power of action are often blunted by insanity, the amount of exercise taken by each patient should be controlled by the physician, so far as may be possible in accordance with the desires of the sick person but always on the basis of a medical opinion as to his needs. The practice of turning patients out like dogs for a daily airing leads to lounging, squatting, and—worse habits. They should at least receive the care bestowed on horses, who are exercised as much as the trainer thinks will be for their good and no more.

Occupation is necessary, first, for the patient's mind, and second, for his body. Mere purposeless exertion, in which the mind has no share, will not suffice to keep a human organism in health; it must work as well as play. I do not think enough importance has been attached to the need of suitable, interesting, and, looking to the number of the insane of both sexes, diversified occupation, which shall be not merely employment but work. I have so often referred to Wakefield Asylum in these pages that I must apologize for mentioning an industrial pursuit recently introduced, by Dr. Crichton Browne, into that institution, which has the merit of being light, not too exacting, and very engrossing. Woman's world cannot, even among paupers, be successfully limited to the

wash-tub; and needlework is chiefly useful as giving employment to the fingers, while leaving the mind free to indulge in its own good or evil pursuits—the Dorcas meeting and the scandal party standing, I presume, at opposite extremes of the range of possibilities. The business to which I allude is the manipulation of mosaic work to a pattern—an employment for delicate fingers, quick eyes, and ingenious wits, more entertaining, and considerably less humiliating, than the old device of sorting coloured beans, purposely mixed to afford amusement. Moulding, if not modelling, might also be added with the view of inducing—as there is, unfortunately, no power to compel—lunatics to do something rather than remain idle.

Amusements within and out of doors are necessary. The latter seem generally more neglected than the former, but in respect to both there is great room for improvement. I am doubtful as to the practice of theatrical amusements—not that there is any uncertainty as to their usefulness when properly conducted; but it is difficult in the extreme to secure a really judicious and successful performance with purely healthful influences. Festive gatherings of all kinds are good when the company is judiciously assorted and the entertainment carefully carried out, but the labour entailed is enormous, possibly sometimes in excess of the reward.

XVIII.—*RELIGIOUS AND MORAL INFLUENCES.*

Religion and morality have especial claims to be considered in connection with the care and cure of the insane. To the influence of religious faith and doctrine, above all to the disturbing and disorganizing effects of religious enthusiasm on weak minds, has been attributed a special variety of mental derangement. It must not be forgotten that the religious instinct—it is more than a sentiment—is admitted by all schools of philosophy to be a component part of the normal system of mental sensibilities, wholly independent of the form in which the faith or feeling may express itself. When, therefore, physicians speak of religious mania, or of insanity caused by religion, I do not understand them to imply that any particular form of belief is chargeable with producing mental

disease—though some creeds and ceremonies may be especially prone to overbalance the mind—but that the religious faculty is the part of the intellectual organism which has broken down. Needless time and some warmth has been wasted in the discussion of a question which, as far as I can see, has not been intentionally raised. Those who deplore the existence of a religious form of insanity appear to me to take up precisely the same position with regard to that variety of mind derangement which all, except fanatics, occupy in relation to the mania alleged to stand connected with drink. They do not affirm that mind disease is the inevitable, or even the frequent, fruit of faith and earnestness; but that it may be either the effect or the cause—most frequently the cause—of the peculiar emotional state with which it is found associated, as I believe is the case with habits of intemperance. More mad people become religious—using that term in its phenomenal sense—than religionists go mad. This is as true as that many victims of mental disease, or bodily disease with mind symptoms, take to drink with a view to relieve their sufferings or without conscious intention, while exceedingly few drunkards, properly so called, become insane. Religion has no more tendency to induce madness than grows out of the pre-existent state of the enthusiast's mind.

There are, however, no influences which can be brought to bear on the mind of a lunatic more potent than those commonly known as the religious. Foremost is the fear of doing wrong, for its own sake—not in terror of punishment, which is a low and poor motive at the best, seldom giving birth to a good, never to a noble, impulse. If the mind of a patient suffering under certain—particularly the impulsive—forms of insanity can be strengthened in its aspirations for goodness, or the desire to do right awakened, where it is dormant, a point has been gained. I am not forgetting the subjective peculiarities of "moral insanity." There is seldom any real desire to do well in those cases. The regret professed is of a kin to that feeble remorse which weak-minded people, who are always going astray and pleading temptation as an excuse, apparently experience. Injudicious modes of seeking to arouse the conscience would doubtless be injurious; direct remonstrance or even exhortation is barred, and should be interdicted; but

there is a way of teaching by illustration, by example, that captivates while it improves, and may do excellent service, without either exciting opposition or suggesting reflections of a self-accusing or excusing character, which may too forcibly bring to mind the morbid weakness of the will. It is of the highest moment that a lunatic should not be induced or encouraged to believe he is powerless in the hands of any power outside himself, whether for good or evil. The beauty of holiness, the blessedness of a pure heart and a peaceable disposition, the excellence of truth and honesty, the priceless character of virtue, the hatefulness and hollowness of vice, are topics upon which a chaplain may descant with judicious fervour, in the confidence that he is helping those around him, if only he has the wit not to worry his hearers, and the tact to teach by story rather than precept.

The airs of the pulpit are wholly out of place in an asylum; its graces should be cultivated, because none are too poor to be pleased. Sometimes one hears a sermon from an asylum pulpit so prosy, so ill-judged, above all so monotonous, that it must take a week of pleasant intercourse with patients to wipe it out of memory. Such discourses do harm. Sermons about death are generally out of place. If the subject distresses any particular patient, he should be treated personally in the wards, or, still better, in the pleasure grounds, not preached at in the pulpit. The chapel service ought to be a cheerful reunion, with bright subjects of thought, ennobling mental pictures—to light up the dull chambers of imagery, and chase out their foul phantoms and creeping things. Many a poor lunatic's mind is a chamber of horrors, a charnel-house, a—hell. The service, and above all the few minutes' discourse, should gleam like sunshine through the darkness, cheering, warming, invigorating the whole being, and quickening and purifying the inner man.

I have condemned, by implication, the conduct of a chapel service for the insane in conformity with the views and symbolism affected by any extreme party in the Church. I must emphasize what I have said: an asylum is no place for the propagation of an exclusive creed. I hold that asylum committees are bound, in justice to the feeling of the majority, to select for the important office of chaplain a man who is wise

and earnest enough to work with and under the direction of the physician, and whose ideas of duty are not of the dolorous type, but such as may admit of his being in all respects useful as friend and teacher to the insane. Such a man will be careful to leave his clique and school, his High, Low, or Broad Churchism, outside the gates when he goes to labour among the weak of intellect and the decrepit of mind. A pleasant, cheering service of song, an encouraging, elevating address, very short, very interesting, fired with the love, the sympathy, the human fellowship, and the thorough-heartedness of the Gospel—as Charles Dickens would have preached it—are worth all the formal, the pretentious characteristics of a ceremonial the meaning of which sane folk seldom grasp, least of all those who lead and perform it. Rightly conducted, judiciously applied, the services of religion constitute a powerful influence to arrest, to direct, to restore the wandering mind. The personal ministrations of a wise chaplain are no less important. When clergyman and physician work together the moral treatment attains its highest development, and some of the most direful and prolific causes of mental disease may be assailed in their strongholds.

Moral influences, properly so called, in so far as they are worthy of the name, spring from the same inspiration and work on the same lines as those more pronounced expressions of the heart's better impulses I have described as religious. It is a grievous oversight when morality, in its real life shape, is not the spirit and essence of domestic intercourse and discipline. I think wards specially set apart for "blasphemers" are a mistake. The foul-mouthed victims of impulsive, or as some say "moral," insanity, and the maniacs to whom cursing and abuse come naturally as the outpouring of a depraved nature, might be kept away from well-behaved patients, but I do not think they should be classed together. The poison of fever gains strength by concentration; vice becomes more vicious by being condemned to the perpetual company of vice. The moral atmosphere of an asylum may be purified by ventilation, as the material is renovated by the judicious intermingling of pure air. The moral condition of some public asylums is corrupt indeed. Frowns and black looks will not mend the state of matters. I have less hope

of the chaplain's influence in this difficulty than elsewhere. There is generally some physical cause—such as ill-temper or bad health—at the root of the morally fetid condition which strikes a visitor. A little careful inquiry and observation would often enable a medical superintendent to discover and remove the cause of the evil. Occasionally—perhaps I had better say, not uncommonly—it will be found in the conduct or character of a worthless or incompetent attendant!

XIX.—*TRAINING PATIENTS.*

Re-education, properly so-called, is an element of treatment; but training patients to the routine of asylum life is a ruinous practice. It tends to confirm the malady and give permanence to the mental defect. If it be necessary to drill incurable cases, for the convenience of those who may have to watch over them during a long and indefinite period, that is a matter with which medicine has no immediate concern. The training which consists in re-educating faculties that have lapsed into childishness or become disabled by disuse during the paroxysm of acute disease, is of vital moment, and, I fear, in its highest sense it is almost entirely neglected. The idea of re-education in an asylum is generally restricted to the enforcement of orderly ways. Under the best management, it seldom rises above an effort to develop decent habits, decorous conduct, and a tolerably equable temper—this last point being only insisted upon so far as the tranquillity of the institution is concerned. There is no endeavour to reinstate and invigorate the governing "principles" of the mind—particularly those which first gave way before the invasion of disease, and were, therefore presumably, the least well-developed or the weakest.

I confess it does not strike me as probable that the mental treatment of insanity will make real progress, or even assert its intrinsic claims to confidence, until psychologists begin to recognize the full scope of its intention. The aim should be to deal directly and specifically with the individual mind organism, its idiosyncrasies, and sources of weakness—those defects which left the citadel of the intellect an easy prey to the

enemy. The rejoinder to this remark will, of course, be that personal treatment is impossible in a public asylum. I might generalize the excuse by asserting that, under one or other pretence, it is neglected even in private asylums, and that explains why the idea is held to be utopian by those who have never tried it. Unfortunately the best, and beyond comparison the most accomplished, writers on insanity—being specialists, and, either at the moment or recently, proprietors or medical superintendents—are committed to the support of the system of treatment extant, and hardly prepared to admit the possibility of anything beyond it. Nevertheless, falling back on the admitted fact that what, for want of a better term, we call the governing "principles" of the mind may be developed by education, I assert they may be strengthened by re-education. Just as a limb stiffened and paralyzed by disuse may be restored by galvanism to first passive, then voluntary motion, the faculties of mind may be restored and strengthened, first to obey, and then to exercise self-control. And success in this endeavour will be proportioned to the intelligent and comprehensive purpose with which the treatment has been addressed to personal defects and peculiarities.

Moral treatment must be individual. It is no more possible to propagate principles of self-control in a multitude of minds dealt with *en bloc*, than to make sincere believers by prohibitory or compulsory religious ordinances. Each mind must be trained on the basis of its own errors, propensities, and weaknesses, just as each case of pneumonia, gastritis, or fever requires the exhibition of remedies and measures of hygiene specially adapted to its individual needs. That such treatment is impossible in very large asylums, I admit; but this fact points, not to the abandonment of moral treatment, or to the substitution of a sham for the real remedy, but to the construction of asylums on the scale of hospitals and the employment of a staff sufficiently strong to deal directly and personally with each case, so long as it presents a reasonable prospect of cure.

XX.—*DISCHARGE OF PATIENTS.*

The discharge of a patient ought clearly to form part of his treatment, but it is, unfortunately, very seldom so regarded. It is not always possible, and it is rarely easy, to determine when a case has recovered, or reached the point where recovery may be reasonably expected to proceed without the aid—or, even better, in the absence—of asylum protection and *régime*. Patients are discharged "recovered," "relieved," or "not improved," at their own instigation or that of their friends, and the grounds of the procedure are not, as they ought to be, wholly medical. In a word, the act is discretionary or managerial. In the case of public asylums, it is generally performed by the committee, on the recommendation of the medical superintendent doubtless, but not wholly unaffected by considerations of asylum economy and convenience with which the physician, as such, ought to have no concern.

There are two well-defined but inseparable aspects of the question whether a patient ought to be discharged. What is his present condition, and to what influences will he be exposed after leaving the asylum? How many of his former difficulties will the convalescent have to face? which of the old exciting causes of his malady must he re-encounter? The responsibilities that will immediately devolve upon him, the scene to which he is to be transferred, the circumstances that will surround him, the life he will have to lead, the labour to perform, the part to assume in a family or society—all these matters should have weight in the formation of a judgment as to the expediency of discharge.

The practice of sending patients out on probation before legal discharge, has divested the question of some of its difficulties, but I am afraid it has done collateral mischief, by weakening the sense of responsibility. It should not be forgotten that, whether the formal act of discharge has been completed, or the superintendent retains a statutory power of recapturing his patient in the event of misbehaviour, as soon as the supposed convalescent has crossed the threshold of the hospital he is alone in the world. Henceforward he must fight the battle of reason against

delusion, hallucination, morbid impulse, and moody states of temper and feeling, single-handed. Is he in a condition to wage that war with good prospect of triumph—I would go further and say, with a tolerable certainty of success? Sometimes it may be necessary to ask if he is even in a condition to exercise *self*-control, without considering the contingency of a struggle with influences that seem to assail him from without. I fear many a poor sick mind is turned adrift without the slightest moral strength to resist "temptation," or to hold the reins of its own conscience. Asylum method, discipline, and protection, have, perhaps, supplied the place of mechanical support to a weak backbone; a crutch to the lame limb, a bandage to the convulsed arm. These are suddenly withdrawn; and, decrepit and disabled, the victim of moral locomotor ataxia, of mental chorea, is exposed to the buffets and business, hurry and confusion, of the world. There has been no effort to train his will, to teach him to walk and act alone; and now, when he is rudely shaken out of his go-cart, he falls, perhaps not to rise again, or, if his fate is less summary, to return permanently disabled.

Until he has been re-educated, no patient ought to be re-exposed to causes which before excited an attack of mental disease. The system of discharge on probation is convenient to the superintendent, but it will offer no commensurate advantage to the patient, unless at least a part of the period of trial be passed in circumstances so contrived as to bridge over the gulf between asylum life and the world, to accustom the convalescent gradually to the renewed duty of self-control, and to keep him under observation so as to detect the slightest indication, not merely of a tendency to relapse, but of inability to press forward in the path of mental soundness and moral strength. I think the provision of intermediate houses between the asylum and the world essential—as a measure of economy—to secure complete recovery and prevent the multiplication of permanent cases growing out of the frequency of accidental relapse.

MISCELLANEOUS.

XXI.—*THE TRAINING OF ATTENDANTS.*

FOREMOST among points of interest and moment in connection with the management of asylums for the insane is the training of attendants. Speaking generally, the officials, upon whom devolves all the personal treatment the majority of patients in public asylums receive, have no more training for their onerous and difficult duties than they may be supposed to obtain, by experience and example, in the wards, while rising from the grade of supernumerary to charge attendants. It is conceded that ordinary sick nurses need training, but no effort has been made to secure the advantages of special instruction for those who are required to nurse and tend the distempered in mind. This would be wonderful, if a somewhat widespread preference for unskilled attendants were not found to exist among superintendents, more particularly the best and most successful administrators. The objection urged against experienced attendants is, in brief, that they have picked up more tricks than knowledge, and any skill they possess is commonly directed to the evasion of rules, rather than displayed in docile obedience to express commands and the faithful performance of personal duties. It is not against the principle of training attendants that physicians in charge of the insane protest, but the sort of training they too commonly receive, which is found to be a drawback, instead of an advantage, as regards their efficiency.

This is the state of affairs we have to face; nevertheless, training is, I think, essential to the highest form of treat-

ment, in which the hourly influence of attendants must always play a conspicuous part. It is scarcely to be expected that men and women, for the most part little above the social and educational level of ordinary domestics, will exhibit the tact, temper, and judgment indispensable to success in the management of the insane, unless these qualities have been developed by special training. It is unreasonable to suppose attendants are thus qualified, without some tangible proof of their ability. It is hardly conceivable that any superior young man or woman should select the care of lunatics as a voluntary preference to household service. There can be no scientific interest, such as that which lures or impels the psychologist and the physician to the study of mental disease; and if we suppose that an individual attendant may here and there be found, who has been induced to seek service in an asylum by a philanthropic desire to expend pains and sympathy on a pitiable class of sufferers, the proportion of such laudable enthusiasts will be hardly appreciable in the multitude of officials to whom the care, and in a large sense also the cure, of the insane is practically intrusted. This is a great subject, and it is one upon which I would give much to write with convincing energy and clearness.

Most of the maltreatment, and a large majority of the so-called "accidents," to which lunatics are exposed, may be traced to the incompetency or carelessness of attendants. No physician, be he devoted body and soul to his work, can be always in the wards. Practically, I think too frequent visiting is worse than neglect. The medical superintendent should appear in the midst of his patients unobtrusively and unexpectedly, but he should not either stay too long or weaken his personal influence by becoming frivolous or "intimate" in his relations with the insane. I must ask pardon for expressing a fear that some physicians err in this direction. They forget that patients with minds diseased are prone to take distorted views of the mental pictures presented to their disordered intellects. If a medical man, in the attempt to express sympathy, allows his words or manner to become flippant, he not only loses mental control, but lays his motives open to the chance of morbid misconstruction. The instant

mental, and moral, control are sacrificed, the patient ceases to look to his physician as a superior. Any respect he feels for him will be, henceforward, the fruit of fear. Knowing the power possessed by the medical superintendent, either to prolong or shorten the term of his captivity, the lunatic may dread, but he is quite as likely to attempt to cajole, as to obey, his keeper. In either event the effect is bad. A playful demeanour is, therefore, in the highest degree objectionable. Familiarity in an asylum, as elsewhere, breeds contempt. It is painful to notice the scant respect shown to physicians by the inmates of some asylums. I am not thinking particularly of those visited for the purposes of the present inquiry. On all accounts it would be undesirable, if it were not also impracticable, for medical superintendents to supervise their patients very closely. The importance of securing efficient assistance is self-evident, and, to be really useful, attendants must be trained. The wild havoc unskilled dressers would play in the surgical wards of an ordinary hospital may be taken as an inadequate illustration of the mischief wrought by inexpert and ill-tempered officials in an hospital for the care and cure of the insane.

The functions of an asylum attendant, besides those of the hospital nurse or orderly, comprise watching, controlling, and encouraging. The official should be ever on the alert—without appearing to keep his patients under annoying *surveillance.* He must have the ready wit to compose differences the moment they arise, to check perilous controversy, to repress indications of selfishness or animosity, and to redress petty grievances; to rouse the lethargic, cheer the depressed, soothe the irritable, control the refractory, encourage the industrious, and, above all, comfort and help the convalescent. And these moral and intellectual duties must be discharged with imperturbable temper and practised skill. The very enumeration of the functions which an attendant is required to perform should open the eyes of committees and medical superintendents to the fact that attendants are, and must always be, the active personal agents in the moral treatment of insanity, and should therefore be, in every case, selected by, and continue directly and solely responsible to, the *medical* authority.

It may be expedient that each physician should train his own attendants, but special training—either in the same or some other asylum—is indispensable. It is to be regretted that little or no time is devoted to the instruction of these important officers. Books should be written for their study, containing something more than bare rules. Lectures and practical tuition, by example and precept, ought to form a feature of asylum management. If medical superintendents would devote time and thought to this matter, the increased success of their practice might show that the effort was not thrown away. Every wise workman bestows a share of his skill and pains on the preparation of his tools.

XXII.—*SEASIDE AND COUNTRY HOUSES.*

Recent research reasserts and sustains the hypothesis that "mental disease" is, in fact, bodily disease with mind symptoms. It follows that the condition of the general health of the insane must be an object of especial solicitude. In chronic maladies generally, change of air and scene is a potent remedy; that measure of benefit and possible relief should not, as a mere matter of policy, be denied to the pauper lunatic. Every asylum ought to have its branch establishment at the seaside. The desirability of this supplementary provision has been recognized of late years, and steps taken, at least by the hospitals and licensed houses, to secure accommodation. A difficulty has, however, been created by the discovery that, while the Commissioners in Lunacy have power to sanction the removal of patients, they do not possess the legal right to enforce compliance with their permissory mandate in the district to which the insane are to be introduced. The magistrates of a county to which lunatics are to be transferred can, it appears, refuse to endorse the licensing powers of the Commissioners. This is a conflict of authority that cannot be wisely allowed. Provided the house selected is suitable, the place chosen with due regard to the resident population, and there are no sanitary or specific objections to the occasional residence of a body of lunatics, as allowed by the Commissioners in Lunacy, no local authority, magisterial or

of any other description, should have power to interfere. If the obstacle recently thrown in the way of this healthful and useful provision for change of air and scene is not speedily removed, a salutary improvement will be checked, and it is most desirable this should be avoided. The benefits likely to accrue to patients from timely transfer to a fresh scene are considerable—in many cases probably enhancing the prospect, and certainly expediting the progress, of recovery. To allow these advantages to be sacrificed in deference to a petty prejudice and authority exercised capriciously, in the supposed interests of a locality, would be shortsighted and absurd. It is possible mistakes may have been made in selecting suitable places of residence. If that be so, the error can be amended; but having obtained the sanction of the Commissioners for a house in any district, the owners or renters ought to be secure in their possession. Opportunity might be offered for appeal to the Commissioners in Lunacy before the licence is granted, and all objectors having a just ground of opposition should be heard, but permission once granted, by the Board, should be final. Speaking generally, the Commissioners need to be armed, and may well be trusted, with higher legal powers.

XXIII.—*CRIMINALS IN ASYLUMS.*

At the close of a singularly lucid and useful paper "On Insanity and Crime; and on the Plea of Insanity in Criminal Cases," Dr. Guy, F.R.S., to whom statistical science is largely indebted both for work done and methods devised, wrote as follows (20th April, 1869, "Journal of the Statistical Society," vol. xxxii.):—". . . We have at this moment within the walls of Millbank upwards of 200 convicts, so unsound in mind as to be deemed fit occupants of special wards, and yet not deemed quite fit for the lunatic asylum—men peculiarly addicted to crimes of passion, violence, and malice; ready instruments of mischief in the hands of the most desperate criminals; most dangerous, destructive, and expensive members of society. . . . If suitable provision were made for the imbecile members of the great mendicant-thief community, by increasing the number and size of our lunatic

asylums, the work of the Poor-law would be greatly simplified, and the cost of crime very largely diminished. Money enough might be saved in this way to defray the cost of a more efficient police both in town and country. . . . The lunatic asylum is not only their proper place, but would be a truly economical substitute, in a large number of cases, for the workhouse, the hospital, and the prison."

It is impossible not to be convinced by the conclusive arguments Dr. Guy has adduced in his paper, and, so far as the general wisdom of recognizing the considerable part which insanity plays in crime, and that consequent expediency of placing persons of unsound mind in confinement or under protection, are concerned, there remains no question. It does not, however, follow that criminal lunatics should be drafted into asylums with the ordinary victims of disease. This method of carrying out a good intention is, in fact, an enormous evil. The presence of such "patients" in county and borough asylums constitutes a perpetual source of anxiety, needless expense, and serious peril. In their report for 1875 the Commissioners drew attention to the fact that "there are at present a considerable number of vacancies in the male division" at Broadmoor. Then why, in the name of common sense, are the wards of county asylums made the receptables of cases which pollute the atmosphere of an institution for the treatment of ordinary mental disease, embarrass the administration, and hamper the work of cure?

There is no more respectable reason for the transfer of criminal cases to ordinary asylums than that which arises out of considerations of red-tape. It would be perfectly easy to charge unions or parishes with the maintenance of criminals in State asylums; but, instead of pursuing this simple and obvious course, the pestilent rubbish is shot into county asylums, where it creates a nuisance which may not be removed, and can scarcely be endured. Medical superintendents are unanimous in their protest against the introduction of criminal cases into their wards. These half-crazed, depraved, and demoralized patients not unusually exhibit an amount of cunning with which it is difficult to cope; they corrupt the ordinary inmates, and incite them to acts of insubordination by the argument that, being "insane," they cannot be punished.

It is also a gratuitous insult and injury to patients, who are paupers, perhaps, only because they have been afflicted with disease, to thrust into their company persons of either sex who have been convicted of crimes extenuated, possibly, but only in part accounted for, by their insanity.

The matter is one of considerable moment, and should certainly be dealt with, in a liberal spirit, without delay. If it be necessary to enlarge existing State lunatic asylums, or to build new ones, the cost might, if that be indispensable, be charged on local rates ; but, however the red-tape difficulty is surmounted, the retention of all cases of criminal lunacy or insanity, occurring during a term of punishment, in State asylums, apart from ordinary paupers, ought to be imperative. It is needless to multiply arguments in support of a policy so manifestly expedient. It would also be exceedingly desirable if the transfers of patients who, having become insane during imprisonment, cannot complete their term of servitude, but are unfit for discharge, could be made to some intermediate establishment, instead of sending them direct to pauper asylums. In a majority of instances these cases are incurable, and might at once be removed to an asylum for imbeciles, where their presence would be less objectionable than in an hospital for recent cases of curable insanity.

XXIV.—*IDIOTS IN ASYLUMS FOR LUNATICS.*

I have alluded in terms of regret to the practice of sending idiots to asylums for imbeciles, by which they are deprived of the advantages that would accrue to proper training. The Poor-law order which compels, or excuses, their removal from special institutions to houses for the demented at the relatively early age of sixteen years is especially injurious in its consequences. The age fixed by the Consolidated Order is often, in point of development—in the case of an individual whose brain, though inert, is not incapable of improvement by use—practically equivalent to a normal age of six years. I am now desirous of making a formal protest against the introduction of idiots into ordinary asylums for the insane, under any circumstances.

The proper treatment of idiocy in a lunatic asylum is practically impossible. The process of training needs a well-organized system of teaching by example, and this can only be carried out in an institution devoted to the purpose, and sufficiently extensive to provide for large classes of scholars. Lunacy cannot be effectually treated in the mass; idiocy can seldom, if ever, be remedied by an individualizing method of instruction. It is through the imitative faculty the dormant brain is to be excited to action. Lunacy is a disease, functional or organic; congenital idiocy is an arrest of development. Sometimes the structure may be capable of greater activity than it has exhibited, and the latent nervous energy can be converted into mental force by stimulating the faculty of imitation. There is little doubt that the mental organism itself may be improved by action excited reflexly; ideas being, so to say, created artificially by first inducing the muscular movements necessary to produce a particular act, and then repeating it until the purpose, which should—normally—precede the act, dawns on the opening mind as a lesson of experience. For example, the movements necessary to tie a knot may be taught by example, and at length perceived by the obtuse senses to be the means of connecting two ends of string, after which discovery the process will be carried out with a purpose.

It is needless to do more than indicate the considerations which make it impracticable to train idiots, except in a special training school with expert instructors. This is generally admitted, though, unfortunately, the dependent proposition—that *all* idiots should be sent to an institution of the class, and to no other—is either not recognized or not acted upon. I feel strongly, and it is my duty to urge, that the presence of idiots in lunatic asylums is fatal to their chance of improvement and injurious to those around. I believe it is impossible to say of any child who exhibits incapacity that it is really incapable of mental work. However closely the cranial conformation may resemble that of the typical "Idiot," training should be tried, not for a few months or even years, but continuously. It is impossible to conceive of any living organ which may not be improved by use; and, beyond question, no mere difficulty in arousing the dormant faculties can

justify the cessation of effort. Development may be very slow—almost imperceptible—and there may, after all, come a time when a partial brightening of the faculties will occur suddenly. It would be as cheap, under proper management, to keep these poor creatures in training schools, as to deprive them of help, by sending them back to asylums, or depositing them in homes for imbeciles. Common humanity points to a rigorous enforcement of the statute which empowers guardians to provide for idiots in separate asylums. The obstructive Poor-law Order, based as it is on a classification by age devised for totally different purposes, should be rescinded.

XXV.—*HARMLESS CASES.*

The recognition of a class of "harmless cases" is the bane of asylum management, just as the notion of "harmless delusions" is the source of peril outside institutions for the care and cure of the insane. The evil consequences are not the same under the two conditions. I see no reason to think the inmates of asylums are neglected when they are held to be harmless. Occasionally "accidents" occur, but it must be admitted that comparatively few suicides or deeds of violence derive their opportunity from any misconception as to the nature of the case. Superintendents, generally, have learnt to distrust the reports of "friends," and even medical informers. When an untoward occurrence disturbs the peace of an asylum, it is commonly the result of some dereliction of duty or wrong-doing on the part of an attendant. The evil which grows out of the recognition of a "harmless" class of lunatics is even more serious than an occasional suicide would be. Upon the hypothesis that "harmless" patients do not require as much attention as those who have in some way exhibited indications of a desire to injure themselves or others, committees base the mistaken presumption that one attendant can be safely intrusted with the control of twelve or even fifteen average lunatics. This is a great evil, and it is of vital moment to insist that what are called "harmless" cases stand in need of fully as much care and personal attention as the suicidal.

The tendency of the modern system of asylum management—that which we see in operation around us, the outcome of the "success" which attended the abolition of restraints—is to let cases drift. I believe this is in great part the cause of the apparent increase in lunacy. Added to the circumstance that old cases removed to asylums have been counted as new, there is the fact that a considerable proportion of those which should end in recovery drift into permanent dementia. Nothing facilitates this more than the creation of a class of "harmless lunatics," into which those suffering from melancholia, acute dementia, and the quieter form of mania, and epilepsy without recognized fits, can be thrust and left to sink, under a minimum of care-taking, and at a cost barely above that of simple maintenance, into incurable disease and decay. No insane person is *harmless* in the only true sense of the term; he is ever doing mischief in mind or body, and may at any moment add physical violence to the sinister mental influence he is perpetually exerting on himself and those with whom he is associated. The figment of innocuous insanity, the excuse for a mischievous and ruinous economy, must be struck from under the feet of committees and asylum managers, if the practice of lunacy is to be rendered both wise and safe.

XXVI.—*IMPULSE AND RESPONSIBILITY.*

It may seem scarcely within the province of this inquiry to discuss the subject of responsibility, and the hypothesis of "impulse" as employed to account for the commission of criminal acts without criminality. I am, however, strongly of opinion that the practical questions raised by a "plea of insanity" can never reach a final settlement until they receive sound and calm consideration, free from penal contingencies; and it is difficult to imagine a more fitting standpoint for the scrutiny of facts than that afforded by the study of insanity as it appears among patients under continuous medical observation. If the overpowering nature of morbid impulse is not demonstrated in the daily life of the insane in asylums, it cannot, with any solid ground of argument, be alleged

as an excuse for persons committing offences under impulse without having been previously recognized as lunatics. If certain acts of apparently sane individuals are to be regarded as the fruits of insanity, that malady, in one or more of its typical forms, must be shown to produce similar fruit under circumstances which place the existence of disease beyond question.

Philosophic dissertations on "criminal responsibility" are numerous, but, however useful as supplying ambitious writers with the occasion for a parade of arguments, they have added little to the weight of evidence by which the common-sense question must be ultimately decided. Much wild nonsense has been spoken in courts of justice, and printed in formal works on this subject, by men who—if they were less preoccupied with the ways of thinking, and sometimes *thought* —might be less brilliant, but more trustworthy; not quite so plausible, perhaps, but incomparably more respectable as "authorities" claiming to influence public, and even judicial, opinion. What the intelligent judgment of the community needs for its guidance is a clear and direct proof that insanity, in its recognized manifestations as a disease, does give rise to impulse so essentially morbid that its nature cannot be mistaken. This being proved, it must be further shown that impulse exhibiting the same characteristic qualities of disease may possess persons not previously suspected to be insane, and impel them to the performance of acts for which—being morbidly produced—they ought not to be held responsible. It is mere waste of words to attempt a philosophic definition of the voluntary act, or seek to draw an arbitrary line of distinction between intentional and consensual activity, meaning to do a certain deed, and being overcome by a compelling power, which subjugates, or inhibits the control of, the will, without perhaps destroying the consciousness. Speculations of this class may be interesting, but nothing more. They cannot satisfy the claims of ordinary, although they may for the moment gratify the taste of an exceptional, sagacity. In plain truth, what is morbid impulse? how is it to be recognized? If these questions can be answered, light may begin to break in on a controversy at present carried on in the dark, and by which the world is rather bewildered than instructed.

It surely cannot be a mere matter of degree, as regards the motive influence. The intensity of an ordinary impulse may be raised to the highest point without becoming morbid. The impulse that impels a man to plunge into the sea, to rush into the fire, or to risk his life in any way, on the spur of the moment, for the rescue of a fellow-creature, can scarcely be regarded as a symptom or product of disease. It is vain to attempt the differentiation of sane or insane impulse by the test of motives. Intentions can only be inferred from acts. Philosophy may recognize the existence of motives without acts, but observation and inference—the only faculties with a *locus standi* in the forensic arena—deal only with deeds done, and motives declared, or inferred from acts. When a person kills or steals it is assumed he meant to kill or steal, unless it can be shown from collateral circumstances, or by inference from the method or nature of the specific act performed, that the latter was not purposely accomplished, or in the doing so far exceeded the implied intent as to leave room for the hypothesis of misadventure. The failure to discover a motive may create a doubt, but unless the accused be allowed the advantage of the uncertainty, the plea of insanity set up on his behalf will not save him. As a matter of fact, I believe prisoners are far more frequently injured than helped by the hackneyed artifice of calling in an "alienist," who, being retained for the accused, cudgels his brain to make out a case of insanity, which generally breaks down in the witness-box, and brings contempt on Science subordinated to private ends. Juries, judges, and Secretaries of State very properly attach scant importance to the opinion of experts who "appear for" a prisoner, and the issue is finally determined on the basis of common sense—with this prejudice against the accused, that his friend in need having created a new suspicion against him, namely, that he is insane, instead of being allowed to go free after some defined period of servitude he is imprisoned for life in a criminal lunatic asylum, a punishment scarcely preferable to death. This is the benefit which the "plea of insanity" too commonly confers upon a prisoner, and when it does not thus act, the case is so clearly one of lunacy that the introduction of special evidence was not needed.

The impulse of insanity must not be confounded with the

sort of impulse to which all uncontrolled minds are subject, upon the failure or cessation of self-restraint, by the effect of physical disease and suffering, or that which is the result of passion and bad temper, or the consequence of evil training or neglect. Probably nine-tenths of the violence and misconduct of lunatics is vicious rather than morbid. Even the epileptic exhibits "modnesse," or rage, in excess of his malady. I see no reason why a man or woman with the gout, or toothache, a "splitting" headache, "fits," or "insanity" should be pardoned for deeds done under an impulse, because his or her passion may have been more easily aroused or quickly intensified than the fury of an ill-nurtured person who has no such excuse. Those who have studied insanity at close quarters—a widely different matter, be it remembered, from having occupied the position of medical superintendent at a lunatic asylum, which simply implies that a man has had an opportunity he may or may not have had time or the wit to use—will bear me out in the assertion that there is not only much method, but a very plain motive, in the mad doings of most depraved lunatics. Indeed, that is one of the pressing reasons why criminal lunatics ought to be excluded from institutions devoted to the care and cure of the insane. It is, as I have remarked, no uncommon thing to hear patients of this class openly or covertly inciting those around them to misconduct, or excusing their own faults, by the sinister argument that, being insane, they cannot be held accountable, and will not be punished. When persons of this way of thinking act under impulse, the impulse is less unsound in its mental quality and manifestation than corrupt in its moral nature.

In what characteristic, then, if in any, does the impulse of insanity differ from that of evil or uncontrolled passion? The answer to this, furnished by experience rather than hypothetical reasoning, is, I venture to think, briefly as follows:—Impulse undoubtedly morbid either occurs in a paroxym obviously connected with a distinctly unsound mental state preceding or following the outbreak, or it is so manifestly irrational in its nature or object as to leave no doubt of its real character on the mind of an observer. I do not assert that there is no form of impulse which may be morbid without complying

strictly with the terms of this definition, but I should certainly hesitate to accept the hypothesis of insanity as a reasonable explanation of acts performed under "impulse"—unless it could be shown that some specific delusion existed, in which case, of course, the mind must be disordered and the individual would be absolved from responsibility, whether he retained some remnant of the faculty of self-control, or was wholly the creature of his own craze and of circumstances. The mind imbued with a "fixed idea"—by which I understand any idea which has usurped the place of judgment and fixed itself—or unable to discriminate between the pictures of special sense and those of thought, cannot with any show of reason or humanity be treated as the master of his actions : he has ceased to be monarch of his own mind. I can readily understand how those who expound a system of mental philosophy which—not content with regarding the operations of mind as the exercise of a force expressing itself, perhaps generated, in a particular series of tissues—denies the existence of any power outside matter, may be prepared to regard man as little better than a machine, the unconscious victim and tool of his fancied self-control and voluntary consciousness. I have no sympathy with this speculation. I think Science is bounded by the recognition that mind is force energizing the nervous organism ; but whether the prime mover is outside matter or generated within, physiology, chemistry, and pathology do not explain. I do not think it is philosophical to base a negative hypothesis on the seeming silence of Nature, and fall back on the old materialism which the development of Science was supposed to have outgrown. That is not a very exalted, although a wondrously self-sufficient, philosophy which denies and denounces all it cannot comprehend.

The justification of a plea of *insanity* must, I think, take the form of a demonstration that the impulse alleged to be morbid exhibits the characteristics of disease, or occurs in the course of a paroxysm of the malady. If the conditions I have endeavoured to define cannot be satisfied, the plea, and with it the pretence of irresponsibility, must fall to the ground.

XXVII.—*CLINICAL SCHOOLS AND WORK.*

At the first blush of the proposition it would seem that wherever there are cases to observe there should be observers, and therefore every asylum ought to have its clinical school. There is, however, another element in the case which must not be overlooked. A school implies teachers. Students cannot successfully, nor should they attempt to, unravel the mysteries of mental disease, except under the guidance of judicious and apt instructors.

It is not right to subject the delicate organism of mind to the explorations of an unskilled inquirer. No pupil or clinical assistant should be permitted to enter the wards of an hospital or asylum for the insane, except with the express cognizance of the physician in charge, and, even with that precaution, the visit should be so arranged that those patients whose cases are not under clinical observation may be spared the presence of an intruder. The mind is a peculiarly susceptible organ, and, when diseased, requires quite as much care as a case of brain fever, secondary hæmorrhage, or stone after lithotomy. I am afraid harm is sometimes done, with the best intentions, when the wards of an asylum are too liberally thrown open to inspection, and, above all, when "interesting" cases are frequently or curiously examined.

The need of instruction in mental disease is urgent and widespread; but the power of profiting by the clinical opportunity which exists at most asylums is limited, and the competency to expound and illustrate cases comparatively rare. Lecturers on the subject of mental disease too commonly content themselves with relating their personal experiences. These recitals are often replete with a certain sort of interest, occasionally they are diverting, but, speaking generally, they fail to instruct. The didactic exposition of disease affecting the mind requires greater learning, a higher tone and method of reasoning, and more finished tact, than discourse on maladies located exclusively in the body. The course on mental disease should stand late—almost last—in the curriculum, and it would be well if it could be always introduced by a few elementary lectures on physiological-

psychology. Clinical observation should follow the systematic study of mind disease rather than be pursued at the same time. The marvellous plates of typical heads, and wonderful collections of anecdotes, letters, and handwriting employed to illustrate the peculiarities of mental disease, are even more misleading than the pictorial embellishments appended to works on general pathology. The latter are so far reasonable in their intention that they aim to reproduce formulated and fixed appearances, which may be identified in the *post-mortem* room, whereas the so-called pictures of mania, melancholia, and the like, are at best but attempts to pourtray a transitory and ever-changing expression, which it needs trained tact to perceive. Even the stare of the patient who peers into dreamland, and the stolid, meaningless gaze of dementia, are beyond the reach of art or photography to reproduce. The expression is a mental phenomenon, and the notion formed of it must be medico-psychological, not less than the fact observed. Grotesque and misleading blunders are made by the student who forms his early impressions of the so-called "insane physiognomy" from plates. He credits the sound with madness, while well-defined cases of lunacy pass unobserved. Unfortunately the misconception extends to practitioners, and hence arise many mischievous and irreparable mistakes. Study from the life is essential to a practical knowledge of morbid expressions of countenance. It is better to trust to the portraiture of words until the features of disease can be examined as they appear in disordered nature. There is plenty of school and hospital work to be done: the pressing need is for willing and able hands to do it.

XXVIII.—*POST-MORTEM EXAMINATIONS.*

It is especially important that the search for organic conditions associated, either in the relation of cause or effect, with mind derangement should be carried out by necropsy. The enigma of mental disease is so insoluble during life that it must on no account be neglected after the death of its victim. There is a wide field of inquiry, and it is not un-

worked. In the county and borough asylums, during 1875, there were 2339 autopsies to 3786 deaths, or 61·78 per cent.; in the registered hospitals, 76 to 219 deaths, or 34·70 per cent.; in the metropolitan licensed houses, 60 to 298 deaths, or 20·13 per cent.; and in the provincial licensed houses, 28 to 204 deaths, or 13·73 per cent.—in all 2503 to 4510 deaths, or 55·50 per cent. Notwithstanding, however, the number of examinations performed annually, it is to be feared few are conducted in a manner, or even with a view, to learn all that can be learnt from the testimony of physical pathology. This is most discouraging.

The pathology of bodily affection with mind symptoms, and the physical traces which mental disease may leave in the physical organism, form subjects of the keenest and most vital interest. Notice of probably interesting *post-mortem* examinations should be given at the principal schools of general disease, and experts in pathology invited to attend. Every part of a body should invariably be examined, because mind symptoms are frequently produced reflexly, by a cause twice removed from the mental effect. Moreover, a uniform method of examining, weighing, and recording the condition of, the several organs should be agreed upon, and generally adopted. There are points of fundamental importance, as yet barely touched, upon which it would be highly interesting and useful to obtain the collective results of inquiries pursued at asylums generally; for example, the actual weight and proportion of the several lobes and convolutions of the brain, the separation being made in accordance with a precise direction, carefully devised and rigorously carried out; the intimate structure of nerves disorganized, either as the cause or consequence of disease. It would be easy to name a score of matters in relation to which an interchange of accurate data would be most desirable.

No mere discovery of "the cause of death" is likely to throw light on mental disease. Comparatively only a small proportion of lunatics die of the malady which has produced the mind symptoms, or, if they do, death ensues upon exhaustion. The pathology of mind affections is an unexplored province of observation. Here and there something may have been gleaned by an individual explorer, but there are no general

facts or even principles to guide the student. Full advantage cannot be taken of the opportunity until men trained to pathological research, and prepared to apply the proper tests for disease to the dead organism, are scattered over the field. The immediate question is, whether something might not be done to improve the passing moment by the formulation of a few leading methods applicable to the collection of trustworthy facts, from which the experts in scientific inquiry might be able to generalize. The case stands thus: Here is a region of research bearing year by year a crop which is wasted; might not the willing services of men needing guidance, rather than skill, be utilized to save something for science? If a pathologist, who has made the nervous system —cerebro-spinal and sympathetic—his special study, would draw up a plain and brief manual, with formulæ for the estimation of weight and appearances, in short, a few simple rules by which ordinary examiners could work, a system of registration of facts might be instituted, and from small beginnings there might hereafter be great results. I throw out the hint; and I believe, if it could be adopted, practitioners in lunacy who are now inert, solely because undirected, would readily co-operate. The point is to establish a practice of interrogating *post-mortem* appearances for the physical concomitants of mental disease, irrespective of the cause of death, to which too many inquiries, in the present shapeless and purposeless state of matters, are restricted.

XXIX.—*ASYLUM REPORTS.*

No one who has had much to do with the reading or writing of asylum reports can, I think, fail to feel dissatisfied with the regulation method approved, or at least adopted. It is, perhaps, only reasonable that the summary statements of visiting committees, stewards, matrons, chaplains, and—in a purely formal fashion—medical superintendents should be addressed to justices of counties, and composed with an evident intent to make the most of what has been accomplished in the estimation of a board principally, if not exclusively, interested to justify the expenditure of public money.

This is undoubtedly an intelligible and obvious policy, against which it would be no less vain than vexatious to urge the least objection. It will, however, be apparent that reports having the ultimate object I have indicated cannot be regarded as affording a thoroughly impartial and clear view of the economic situation, while for medical purposes they must be practically useless. It is, unfortunately, the fact that reports and returns made with a view to the satisfaction of the Commissioners in Lunacy are almost equally worthless.

In the course of this inquiry I have examined, with more care than is usually expended on the perusal of documents of the class, a considerable number of reports, and in the hope of placing the materials for a critical judgment as fully as possible before my readers, I have made copious extracts. If I am not mistaken, the passages cited will, speaking generally, confirm this opinion, formed on ampler premises. Much which would otherwise be valuable is marred by the evident accommodation of dicta, if not also data, to preconceived or enforced views of what the interests of an establishment and its directorate are supposed to require. Not even the reports of a superintendent so able and independent as Dr. Conolly proved himself, are free from the colouring of prejudice for or against particular authorities or influences; while in certain instances the opinions expressed bear evident tokens of being toned down in deference, or distorted in a spirit verging on sycophancy, to powers at the moment dominant either in the committee, at quarter sessions, or in Lincoln's Inn Fields.

I have no wish to dwell on this uncongenial topic, but it is incumbent to say, in passing, that medical superintendents who consent, or permit themselves, to behave as the docile servants and advocates of committees, when preparing their ordinary reports or furnishing special rejoinders to counsel offered by the Commissioners, not only forget their position as members of a profession which must needs be free and outspoken, in the public interests, but break faith with Science by withholding or placing a false construction on the lessons of medical experience. It should be needless to insist that practitioners engaged in lunacy are responsible to the profession, and through it to the community at large, for the acquisition of knowledge, and the communication of facts and

impressions collected in a province in which we are all deeply and keenly interested. Little indeed can be discovered to throw light on the nature of mental disease, or to guide the efforts made for its cure, without the honest and unwearied aid of those engaged in the medical care of large bodies of lunatics, under conditions in which a considerable number of facts may be viewed in juxtaposition and compared, while experiments on a sufficient scale are possible. If the opportunities and consequent responsibilities of practice in these institutions were realized, and professional and public obligations adequately felt, a spirit of higher independence would animate the medical officers of asylums generally, and the duty of reporting on the etiology, the pathology, and the therapy of mental disease would be better performed.

Science and humanity call for a class of medical reports differing widely from the mass of statements furnished in the returns made to visiting committees. In *The Lancet* report on Bethlem I took occasion to express regret that certain appendices bound up with the official reports were addressed, "For the Information of the Governors," while dealing with subjects which no lay committee can be expected or desired to comprehend. I have cited in the statistical notes on Bethlem Hospital, at pages 310–11, vol. i., extracts from a paper —by the assistant physician—unfortunately relegated to the obscurity of the Guy's Hospital Reports, a mode of publication not less inappropriate than would be the contribution of a budget, by the Chancellor of the Exchequer, to the "Journal of the Statistical Society." Guy's Hospital Reports do honour to the institution whose name they bear, but it should not be forgotten that while the interests of medicine are cosmopolitan, those of Guy's are limited, if not local. It is conceivable that members of the profession who would derive profit and pleasure from the study of the able paper, from which I have quoted only a few passages, may not have heard of these "Reports," or know where to procure them. In the main they concern the *clinique* of a particular school. To enshrine the clinical experience of Bethlem Hospital in this fashion is to put the candle under the bedstead with a completeness extraordinary, if not inexplicable. The West Riding Asylum medical reports have been maltreated in an

opposite direction. Summaries of experience of high value have been given to the profession in an independent volume, bound up with essays of no authority, obviously the work of young disciples rather than apostles, and vitiated by proofs of the wildest generalization and the weakest powers of accurate observation. The worth of many masterpieces in these reports, issued under the auspices of the ex-medical director —some of them from his own pen, and therefore of high significance—should have forbidden their appearance in a periodical, a considerable percentage of the teaching of which is worse than useless, because misleading; and in which, strangely enough, writers wholly unconnected with the asylum have been allowed to disport themselves. It is impossible, regarding the medical statements of asylum practitioners as the only sources of trustworthy information on the subject of mental disease, not to feel that no outsider, whatever his ability, should be allowed to mingle his lucubrations with the well-considered reports of responsible officers.

I think it is to be regretted that the superintendents of asylums do not more constantly avail themselves of the ordinary medical Press for the dissemination of their treasures, when they would have the whole profession for an audience. The journals of the specialty are absolutely useless as channels of intercourse with the outside world of medicine. They cannot, of course, be read extensively, beyond a limited circle of alienists. Practitioners engaged in lunacy may be assured their works will be esteemed of higher honour by the profession at large, than in their own limited province, for the very plain reason that medicine, as a general science and art, confessedly needs their assistance.

XXX.—*FRUITLESS RESEARCHES AND FALSE DATA.*

It is, unfortunately, a common practice to eke out the meagre medical interest of asylum reports with tabular statements, and more or less formal reflections, in connection with topics upon which the superintendents of hospitals and houses for the insane cannot possibly possess trustworthy information.

Nothing, for example, can be more unreasonable than to ask asylum officials for information as to the "causes" of insanity, the duration of the disease, the early symptoms—in short, the previous history of patients intrusted to their care. It is in the highest degree improbable that communications made to the medical officers, either by patients or their friends, will be accurate. If the case is one of long standing, those who must be half conscious of neglect in not placing it under treatment in an earlier stage will naturally be oblivious to indications which should have suggested an asylum months or years ago. If it is recent, precursory symptoms will be no less effectually effaced from memory, and even a previous attack may be forgotten. The exciting cause is sure to be confounded with the predisposing; and, of two or three possible modes of explaining the attack, that will be preferred which reflects most severely on others, or tends to elicit sympathy for the afflicted, as the case may appear to the informant more or less natural in its occurrence, or carelessly, perhaps even wantonly, induced. The sources of error are so multiplied by the relation in which friends and patient stand to the officials of an asylum that, in regard to a disease so mysterious in its attack and uncertain in its development as is insanity, the notion of collecting materials for a judgment from the second-hand evidence furnished by asylum reporters is manifestly ridiculous.

I write strongly on this subject, because mischief is being done by asking medical superintendents to engage in fruitless researches which result in the accumulation of false data. Better have no information than provoke mere assertions which acquire groundless authority from being made in response to official inquiries. Medical superintendents would confer a boon on science by declining to compile tables purporting to give the "cause" and the "duration" of the disease. It is absurd and misleading to give formal expression to the stories told by "friends" and patients in connection with these matters. I doubt if it be possible even to determine whether the attack is a first or second accession of disease, except in cases having an asylum history. As well ask the schoolmasters of Board Schools to report whether their scholars have had the usual number of infantile diseases,

and if so, where and when they were "caught," as expect medical officers of asylums to report on the previous lives of their patients. The voluminous tables published in reports on this subject are, in fact, worthless, and ought to be discontinued. They can only lead to misconception, and are therefore mischievous.

Meanwhile, the causes of insanity, the duration of the disease, and many circumstances connected with its early history, need to be investigated. For example, we can never hope to solve the mystery of general paralysis, or to fathom the peculiar conditions which not unfrequently determine the development of mind symptoms reflexly, when tubercle is deposited—in which case the ordinary course of the physical disease is interrupted, as during pregnancy, or so masked that its presence may remain for years unsuspected—unless the history of insanity can be traced nearer to its opening. How is this to be accomplished? I can see only one way. Specialists cannot possibly study incipient disease, for the sufficient reason that cases do not fall under their notice until advanced mental symptoms have declared themselves, and this happens late in the malady. Those who recognize the reflex causation of insanity will at once perceive the folly of looking to asylum experience for help in the inquiry. It is only by enlisting the interest of general practitioners, for the early history of lunacy, we can succeed in obtaining information. Materials among which it may be possible to investigate the causes of mental derangement, and the indications of its access, as well as to fix the date of attack, must be collected outside asylums. If a better system of registering cases could be inaugurated among Poor-law medical officers and private practitioners, and the attention of the profession at large were directed to the elucidation of incipient mind-disorders, especially in relation to the generic diseases known as general paralysis, tubercular or pulmonary phthisis, and epilepsy, this province of medical research might be occupied in force, and with some hope of success. Meanwhile, the practice of reporting upon such topics at asylums ought to be discountenanced.

XXXI.—*COST.*

Professor P. Martin Duncan, F.R.S., in an interesting paper which appeared in No. 26 of the *Quarterly Journal of Science*, April, 1870, has treated the question of expense with singular clearness, and as practical men would prefer to have it discussed. The vital question is, does the money spent produce an adequate return, that is to say, a larger number of cures per cent. of the cases submitted to treatment than could be obtained at the same cost by any other mode of procedure? The actual amount expended must be a secondary matter in any sound commercial calculation, because the problem is to reduce the plague by stamping out the disease. Professor Duncan puts it quaintly and forcibly: "Thirty-five years have elapsed since Prichard's celebrated treatise on insanity appeared, and during that time the asylum system and the 'moral management' treatment have gradually attained a great development; that is to say, the old miseries of the insane have, to a great degree, been replaced by conditions which, at least, are very satisfactory to the public. If insanity were not a curable disease, if it were perfectly beyond the reach of remedies, and if it were a special affliction far beyond the influence of material entities, civilization might be congratulated upon having influenced the minds of men in the direction pointed out by the philosophy of Christianity. Fine buildings, many of them admirably adapted for their object; delightful grounds; elegant corridors, hung with pictures, ornamented with flowers, and decorated with taste; a large staff of nurses and attendants; well-educated and benevolent medical men; a perfect system of hygiene, diet, and supervision; and sedulous Commissioners and visitors. These are the most prominent accessories of the modern system, and they are most creditable to humanity. But when Hodge's wife leaves him in a snug ward, whose surroundings are quite palatial to her wondering senses, and returns to her dirty hole of a cottage, to satisfy the hunger of half a dozen young children upon bread, dripping, and tea, she wants to know whether all this splendour will cure her John safely, quickly, and pleasantly, and what he will think of

home when he comes out." This is the gist of the practical question.

It is little use augmenting the expenditure if, as Professor Duncan implies, certain impracticable people are scarcely wrong in asserting "that the magnificent accessories of the treatment of insanity have not been of great assistance to humanity. They urge," he says, "that lunatics are not more frequently cured than they used to be; that the number of recoveries from insanity has not been increased; that the holding down of violent patients and the fracturing of their ribs by keepers is not a bit better or more Christian treatment than placing them in strait-waistcoats and fastening them down with straps; and that the whole asylum system is uselessly expensive and detrimental to the majority of the insane, and unphilosophical, especially as no measures have been adopted by the State to prevent the occurrence of that misery and pauperdom which develops lunacy. Many independent thinkers," continues the Professor, "whilst they admit the sedulous care that is taken of the insane in asylums, and believe that cruel treatment is very exceptional, are by no means satisfied that much progress has been made by medical science in the cure of the alienated. The inmates of asylums are well taken care of, and they are as comfortable as they can be; but, with all this, there is a doubt whether the cures increase year by year with the experience of the psychological gentlemen. There is even a doubt expressed about the applicability of the asylum system to many cases of chronic insanity, and the Commissioners hint at a want of individual attention to demented patients. Certainly the Commissioners have forced the present system of shutting up all lunatics upon the nation, and have necessitated an enormous expenditure; but it becomes a serious question whether the whole of the insane who are not affected with the disease in its acute form, and who are not dangerous to themselves and others, would not be better off under very different circumstances than those of the model asylums."

There can no longer, unhappily, be room to question the abortive character of recent efforts to raise the percentage of cures. Whatever else the present inquiry may have left unsettled, this particular point has, I submit, been cleared up.

Those who argue that nothing definite can be inferred from data so vague as the returns of cures forty-five, thirty, or even twenty years ago, will find great difficulty in disposing of the unanimity with which the figures and facts collected tend to show that there has been no substantial advance. My own view of the case differs from that propounded by Professor Duncan only in that I think the Commissioners must not be held responsible for the defects of a system which, as far as it will go, they have admirably carried out. I find in their Reports unequivocal proofs of a desire, and persistent effort, to cope with the evils of insanity, by weeding asylum populations of the very class of patients Dr. Duncan, in common with most observers, is anxious to see removed. In the paper from which I have quoted, the author proceeds to assign causes more than sufficient to account for the inadequacy of the results obtained. His reasoning covers the ground occupied by earlier and later writers, and I fear there is not much that is new in the present pages, beyond a more detailed specification of the evils of stagnation, and the causes which have tended to bring that condition about. Meanwhile all this intensifies the need of investigating closely the question of cost.

Speaking generally, asylum provision has been, like shipbuilding and gun-making, an enterprise more extravagant in amendment than original work. Public institutions have cost, in many instances, much more in necessary alterations than in primary construction. To some extent, doubtless, this has been inevitable, because the progressive change wrought in professional and public opinion during the last forty years has rendered it impossible for designers to keep pace with the movement. Much needless expense has, however, been entailed by prejudice, rather than mere errors of judgment corrected by experience. Asylums have been built to a conventional pattern by architects, who, of course, could not be expected to recognize the fact that the man who is about to employ an apparatus is the proper person to be consulted as to its construction. The mistake has been simply this : asylums have been provided as places of safe custody for lunatics, and a medical officer has been subsequently appointed to reside on the premises and take care of the inmates. Nothing could be more opposed to the

scientific and economic method of procedure. The circumstance that asylums have not been designed for *hospitals*—or, if some general thought of a curative intent has glimmered in the minds of designers, there has been no practical acquaintance with the nature of the medical apparatus required—explains the persistence in modes of construction long since shown to be unsuitable.

There is no way of reducing the burden on the public for the maintenance of lunatics—and their dependent families, often thrown upon the rates—except that which I have indicated elsewhere. A serious attempt must be made to diminish the average number of the insane requiring support—1. By curing the curable more rapidly; 2. By preventing sluggish cases from becoming permanently demented; 3. By weeding the asylums of patients who may be maintained at less cost elsewhere; 4. By placing all who can work in a condition to perform remunerative labour within, or outside, special institutions. I may add that it is my strong conviction the time cannot be far distant when *work*, with a serious purpose—not mere desultory employment—will be recognized as one of the most important elements of treatment. When this measure of enlightenment has been accomplished, medical superintendents in public and private asylums will be intrusted with the authority to make their patients labour, as they have now the more perilous power of placing them in restraint and imprisonment. In public asylums, at least, the large amount of mental and physical force now injuriously wasted will be usefully employed, to the remedial advantage of patients and the relief of struggling ratepayers outside, whose by no means insignificant interests have been too ruthlessly crowded out of sight. The asylum system is costly in excess of its value as an agency for the care and cure of the insane. If we inquire closely into the causes of the increasing expenditure, I think they will be found to be of a nature which cannot be regarded with approval or complacency. The additional outlay does not represent augmented comfort to the inmates of asylums, or greater facilities for their relief and recovery. The money is allowed to drip away in doles in aid of an endeavour to stave off outlay. There is no more ruinous waste than the extravagance of patching up a worn-out system, which ought to be swept boldly away.

XXXII.—*THE STATISTICS OF LUNACY.*

The story of statistical research in connection with the spread and treatment of insanity would be interesting and instructive, were any one gifted with industry to collect the necessary materials, and with the acuteness requisite for the exposure of a lengthy and complex series of fallacies. Probably few departments of inquiry have been the scene of more mysterious misconceptions. A bog, over which myriad bewildering lights dance and delude the traveller, would be a faint picture of the perplexing and impracticable province that lies before the explorer who attempts to investigate the subject of lunacy by way of statistics. What constituted insanity fifty years ago, and what is it now? What did the reporters of forty, or even thirty, years back mean by cures; would their notion satisfy the divergent notions of any half-dozen physicians to-day? Questions of this nature, at once confounding and inexplicable, block the threshold of the inquiry; while if, surmounting these preliminary difficulties, the student seeks to discover the proportion in which the several forms of disease prevailed at any particular period, and essays to compare the assigned causes of death at different epochs, he is brought face to face with obstacles which not only baffle ingenuity, but defy the possibility of any just conclusion. In truth, the data do not exist for a trustworthy retrospect. I have waded deep in the mire of the subject, and it remains to confess that no single result I have been able to reach is, in my judgment, more than approximately or relatively accurate.

The objections which candour compels me to take generally to my own conclusions, doubtless apply, with scarcely less force, to the whole series of returns published under the authority of the Registrar-General. For example, when it is alleged that a given number of individuals have died of any disease, the statement is vitiated by the fact that it rests on no more solid foundation than a heap of bare assertions made by some thousands of practitioners, not half of whom probably were so circumstanced as to form a true diagnosis, while a comparatively small proportion have taken the pains to deter-

mine whether the disease named in the certificate was the actual cause of death, or only accessory, if indeed it had any real existence. There is no practical remedy for this defect of detail. Classifications of disease are all very well in their way, but, like the carefully prepared schedules of an income-tax paper, they afford no guarantee of the accuracy with which a return is made to the assessor. It is impossible that "facts" so collected can ever be satisfactory. There will always be nearly as many sources of error as units in the sum of inference.

To these factors in the general confusion must be added the pregnant circumstance that as fashion changes—or, shall we say, Science advances?—the views of practitioners are modified, and what was returned under one heading last year will be placed under a totally different designation next. This is especially noticeable in the matter of "assigned causes" of death in the reports of asylums. A glance down the columns of most of my tables, particularly those embodying the returns of the older asylums visited, will make this painfully evident. For example, one year there will be no deaths from "general paralysis;" the next, a considerable percentage will be ascribed to this malady. It is, of course, inconceivable that these figures express the facts. The explanation will probably be found in the circumstance that a new man has assumed the position of responsibility, or the existence of the malady has suddenly dawned on the consciousness of the reporter. The same uncertainty attends returns of death from "consumption," which is sometimes lost in the vague description of "pulmonary disease;" at others, set out with a fulness which seems to imply that the practitioner reporting has become possessed with the belief that the major portion of the insane community have lungs impregnated with tubercle. I have endeavoured to check the returns made, by every means at my disposal, and the figures embodied in the tables presented are, I believe, as accurate as the conditions will admit: it is, however, incumbent to state, once for all and pointedly, that no certain stress can be laid on these results of the inquiry, and I fail to see how data can ever be collected, from past, present, or any future compilations of returns, either in lunacy or general

medicine, upon which it will be possible to found really trustworthy conclusions.

I am aware that in making this statement I dare to differ from high authorities. It may be that I take a too despondent view of the prospect, but it is not apparent how the mean of divers powers and degrees of medical acumen and scientific fidelity is to be found and applied to the verification of a multitude of certificates signed, and returns made, under no sense of responsibility, and without even the incentive to care and accuracy which might attach to the discharge of a public duty, recognized by the State and suitably requited. A logical *reductio ad absurdum* of the system at present in force might, I think, be effected by calling upon practitioners in jurisprudence to return the precise cause of their failure, in every action at law in which a client was worsted. A fair proportion of such returns must, of course, by implication at least, record the omission of the legal expert to recognize the real cause of the reverse until too late to avert the catastrophe. Setting aside the part which different notions of morbid phenomena, and varying powers of diagnosis, must play in the result, how many *assigned* causes of death are, in fact, the formulæ by which a painstaking, but incompetent, or preoccupied practitioner covers the avowal that he has wholly failed to obtain any clear perception of the case he has been treating!

Are the statistics of lunacy, then, of no real value? To this very natural question, I emphatically reply they are of great and practical importance. While little better than worthless as data for a detailed estimate of the results obtained by treatment, or the specific manifestations of disease, the relative proportions brought out in the series of tables compiled are of great general significance, and the total percentages, when studied in comparison, will tend to throw new light on a subject hitherto veiled in needless obscurity.

The points upon which reliance may be placed are the following:—The numbers of admissions, and proportions of the sexes; the numbers of deaths, and proportions of the sexes. The recoveries may be taken as sufficiently marked improvements to render discharge colourably justifiable and presumably safe. The proportions per cent. of re-admissions

on recoveries I have introduced as some check on the verity of the "cures." If the statistician will read *cases* for "patients" in his estimate, he cannot go far astray in accepting the recoveries thus checked as data for the test of treatment. The average ages at admission, recovery—understood as I have qualified the term—and death may also be trusted. In working out these matters care has been taken to throw out "unknown" cases, and the mean of each period of years has been computed with pains to eliminate every apparent source of error. I do not think any fallacy is likely to have run through the whole of the sums, and those which have crept in probably counterpoise each other. In any case, the multitude of data presented in the several reports, the small difference of the various returns, the close agreement of the estimates for many years, attest the general accuracy of the statements made. Whatever may be the precise value of the figures which have been worked out, it is, I think, beyond question that the relation the several ages bear to each other is trustworthy. The dependent numbers—for example, those of the average resident and remaining populations—are, of course, susceptible of proof, and the percentages may be verified. Proportions per cent. can never safely be accepted singly as the bases of an inference. Several have, therefore, been introduced, and they must be taken together in the formation of a judgment.

With these qualifications, I have no hesitation in believing the statistics of lunacy, as set forth in this work, may be serviceable, remembering always the limits beyond which it is unsafe to trust them, and the boundaries of the area within which they have been collected. If it should, hereafter, be practicable to enlarge the scope of the inquiry so as to include similar institutions throughout England and Wales, I think we shall possess a collection of data which cannot fail to have an important influence on the general opinion entertained as to the prevalence, duration, and curability of insanity. It is needless to point out that the field at present explored is not of an extent to justify general deductions. Moreover, as I have explained in the first of these Notes, the asylum populations of the country can never represent the aggregate of insanity in the community as a whole, either in the aggregate or in proportions.

I have purposely avoided any discussion of the vexed question whether insanity is increasing. The means for a final judgment on that subject do not exist, and without data of sufficient accuracy it is impossible to proceed one step in such an inquiry without danger of being led astray, and perhaps induced to take up a false position by the seeming force of some pretentious fallacy. I will only allow myself to say that I fail to recognize any sufficient evidence of increase beyond the increment of the population. The alleged proofs of extension, when viewed at close quarters, turn out to be signs of local accumulation. The intelligent physician does not infer that the total quantity of blood in the body has "increased," because certain organs are congested! For the present I prefer to say insanity shows a tendency to *accumulate*. I think this may be asserted; and the circumstance is not satisfactorily explained by any one of the hypotheses set up by ingenious writers, or by all their theories thrown together to eke out deficiencies. It may be true that persons are now considered insane and locked up in lunatic asylums who would have been deemed fit to remain at large years ago. Possibly it is the fact that cases are sought out and placed in confinement with zeal worthy of a better enterprise. I am prepared to admit that the working of the Poor-law system, as developed among us, tends to make the description of insanity and unsoundness cover a multitude of inconvenient peculiarities only colourably connected with disease, and to crowd asylums with paupers who might be safely classed as "infirm" or even "able-bodied" in the workhouses. Nevertheless, having made ample allowances for the contributory effect of these and other causes of apparent increase, I think there is a real increase of the *proportional* number of the insane in confinement. The statistician will not need to be again reminded that this may be the fact without any increase of the number per cent. of the population becoming insane. If the inmates of asylums live longer than they did years ago, if a larger proportion of the cases under treatment neither recover nor die, but pass into a condition of chronic dementia, the accumulation of cases must produce an increase of the resident population of asylums. I believe both these causes of increase are in operation. The average age at death has

been slightly raised, and is increasing. Patients live longer, and more of the recent cases become chronic, than when the measures employed for their cure and coercion were violent, and entailed great risk while they applied a strong stimulus to the dormant faculties. This obviously has the effect of reducing the proportional number of patients discharged "recovered," while, in the absence of a well-ordered system for the removal of chronic cases from the hospital population, the "average number resident" and the "total number under treatment" in asylums are both augmented.

The lessons of the inquiry would not justify me in pursuing these speculations farther. Figures may so readily be converted into fallacies that it is perilous to generalize a hair's breadth beyond the plain warranty of facts.

XXXIII.—*LUNACY LAW REFORM.*

The need of extensive reform in the laws relating to lunacy and lunatic asylums is felt at all points, and generally admitted, by those concerned in the care and cure of the insane. Opinions, as might be expected, differ widely with respect to the direction new measures should take. Some would gladly see existing statutes relaxed, so as to leave greater scope for the exercise of a personal judgment in the treatment of cases; in fact, making it optional whether they shall be removed to an asylum or treated among friends, either singly or in association, without the formality of certificate and the supervision of a public board. The number of persons who entertain this opinion of the reform expedient may not be great, but it has obtained a strong hold in certain quarters, and it is difficult not to believe a wish to take this retrograde step lies at the bottom of much recent agitation, and—unconsciously, perhaps—inspires the policy which has found favour with the Scottish Board of Commissioners. It also gives the keynote to the party of administrators this side of the Tweed, by whose counsel asylums are conducted, and their officers controlled, as though the notion of curing insanity could not be seriously entertained, and the old idea of

"madhouses" and "keepers" might, with economy, be revived. Another class of reformers desire to see the law for the protection of lunatics made increasingly stringent, and their custody confided to none who have not established a claim to confidence by devoting years of continuous study to the specialty of mental disease. It is impossible not to feel more sympathy with enthusiasts of this way of thinking, than with those who, taking for granted that insanity is incurable, would destroy the chance of benefit by withholding the means of cure.

The true course of reform lies, I believe, between these divergent indications. Insanity is not less amenable to treatment than other derangements of function, when it occurs unassociated with brain and nervous disease. The fact that no large measure of success attends the particular method of remedy employed, is probably due to inherent defects, which have been already exposed. The laws devised for the protection of persons labouring under mental disease cannot, with safety, be relaxed. Indeed, they need to be more clearly defined, and the rein of government drawn tighter. If I were asked to name the measures which, after long and careful inquiry, extending over many years, seem to me desirable, I would emphasize the following:—

1. That the Board of Commissioners in Lunacy should be armed with power to enforce the recommendations of its visiting members—after ratification by the Board—upon the visiting committees of County and Borough asylums, and the governors of hospitals; and the power of compelling compliance on the part of proprietors of licensed houses should be more direct than that contingent upon the discretion of refusing to renew a licence.

2. That patients labouring under mental derangement should be removable to a public or private asylum, as to an hospital for ordinary disease, *without certificate.* Within eighteen hours of admission, notice should be sent to the office of the Commissioners in Lunacy, and an order be issued from the Board to an official medical examiner—duly appointed by the board and not engaged in private practice, either as medical attendant or medical witness—who should at once proceed to the asylum, and report directly to the

Commissioners as to the nature of the case and the expediency of detaining it. If residence in the asylum were deemed desirable, the Commissioners could make an order to that effect—such order to have the legal force of a certificate of insanity—and by the visits of their inspectors provide for the continuous watching of the case. In this way, for twelve months at least, every new patient would be kept under official observation, a measure which could scarcely fail to exert a satisfactory influence on the treatment.

3. That the power of signing certificates of lunacy should be withdrawn from ordinary medical practitioners, magistrates, and clergymen, and intrusted only to the locally appointed agents of the Lunacy Board, who, as I have said, should not be allowed to engage in practice, or appear as skilled witnesses in courts of law on the subpœna of any party to a suit but only, as occasion might arise, at the summons of the court. The officers appointed to discharge this duty of certifying and supervising lunatics might be the medical officers of health of convenient districts, but before receiving a licence they should be required to possess a special qualification in lunacy, obtained by examination before one of the medical licensing bodies willing to undertake the duty. The effect of this enactment would be to give a stimulus to the study of mental diseases, which nothing short of the legal requirement of a special qualification can supply.

4. That the possession of a licence to take charge of a lunatic should be enforced, in the case of a single patient, as rigorously as in one where two or more reside under the same roof. It is as necessary to throw the protection of the law over patients living apart, as over those associated. Abuses are even more likely to occur in the treatment of single patients than of several placed together in an establishment for the purposes of cure. The extra work thrown upon the Commission should not be allowed to weigh against this proposal. Additional help might be provided, not by the appointment of assistant Commissioners—which would, I think, be a grave mistake—but by the appointment of local officers, empowered to sign certificates upon orders issued from the central office of the board, and charged to visit new patients—as distinguished from asylums—at intervals, until the expiry of a period during

which the condition of curability might be expected to become exhausted. These agents, as I have suggested, might be the district officers of health, whom it is most important, on general grounds, to relieve from private practice and endow with an exclusively official character.

The cardinal measures of reform thus indicated would cover a multitude of minor details which it is important to amend. The change I propose is certainly sweeping, and it will encounter the strong antagonism of many who are content with the system extant. Visiting committees of justices will demur to the extension of an authority they steadily resist. The project of giving governing powers to the Commissioners will excite the opposition of committees of County and Borough asylums, and governors of hospitals, and the strenuous objection of proprietors of licensed houses, who sometimes feel aggrieved by the discretionary authority to refuse a licence, which the Commissioners at present possess. I fear the medical profession will be unwilling to resign the privilege of signing certificates, notwithstanding its acknowledged incompetency for the business to which it clings. Nevertheless, I urge the scheme submitted, on the consideration of the Legislature, and I believe it will be found to embody the outline of efficient reform.

CONCLUSION.

THE inquiry of which I have now given the particulars has been conducted with a view to accuracy of detail rather than systematic exposition. It has been essentially a *study* in progress, and as such it is presented. The circumstance that no comprehensive, and at the same time precise, retrospect of lunacy practice during the last half century existed, must have occasioned surprise in the minds of students and practitioners. The story of that reform in the care and cure of the insane which commenced in this country with the establishment of the Retreat, near York, about 1796, has, indeed, been recounted by able and eloquent writers, and works comprising able reviews of the general progress made have appeared at intervals. Most of these I have cited. Meanwhile, no attempt has been made to collect in a single work the principal statistics of this great subject, around which so many grave interests gather.

I have not ventured to give the materials collected in these volumes a shape more coherent than their natural connections may determine. Indeed, I have endeavoured to leave the data as little impressed with my own prejudices as was possible. If, as I believe, the lessons of lunacy statistics are replete with warning and suggestion, any effort of mine to make them clearer or more cogent would probably have impaired their value.

I think those who examine with an impartial judgment the picture my tables and extracts offer for contemplation, must feel that on nearly all the leading lines of advance and

improvement there has been more of stagnation than progress, since the emancipation of the insane from a state of bondage and imprisonment with the professed purpose of bringing them under the benign influence of a curative *régime.* I will not restate the reasons for this conclusion; they have been reiterated in the course of my reports and remarks. Suffice it to repeat the assertion that, although the practice of using mechanical restraints received its death-blow at the hands of Conolly five and thirty years ago, the logical conclusion of his enterprise has not yet been reached; and there has been no adequate effort to replace the bad and mischievous system his personal exertions and the encouraging influence of his example uprooted, by a well-devised and scientific system of moral treatment, such as he certainly proposed. His own hand seemed to grow weary of the work, and his followers have, as a rule, been content to let matters lie as he left them. Philanthropists, animated only by feelings of humanity, were not unnaturally satisfied with the reform effected; and the insane being liberated from their chains and kindly treated, public opinion rested from its enterprise of mercy, and appeased, if not content. The circumstance I should like to see discussed by writers on insanity, and, if possible, explained by medical practitioners among the insane, is that there has not only been no substantial improvement in the results obtained since the abolition of the restraints; but what amounts to a positive diminution of the proportion of cures, —when the general condition of the mass of patients under treatment is fully considered—seems to be the consequence of a recourse to measures which promised high and increasing success.

I have hinted, in the Note on this subject at page 164, that the disuse of violent measures of coercion had its drawbacks. I would again urge that, although the insane generally are spared much grievous and wanton suffering by the abolition of restraints, they have less chance of being cured under a system which not only spares needless irritation, but affords great and grave facilities for what a Scotch Commissioner has characterized as "drifting pleasantly into dementia." When the excited maniac was encased in a strait-waistcoat, he raged and played the madman to the full; but the moment his fury

ceased, his bonds were generally removed. This change of treatment produced a mental effect, which, if it came into play at the right moment, gave an impetus to his recovery which carried the case over the dead-point and sped its cure. All this advantage may have been worth is lost to the patient under the present system ; and, though I am well assured no sensible man would wish to revive the old practice for the sake of any collateral good that may have grown out of the evil, it is a grave question whether the mild and uniform method now adopted does not require a measure of watchfulness and personal attention to individual cases which has never been accorded, and is in fact impossible, in the colossal establishments to which the modern treatment of insanity has given rise.

The lessons I think this inquiry should teach are—First, that the existing method of dealing with lunatics is chiefly notable for its negative advantages. It is free from the objections which public opinion urged, on grounds of humanity, against the restraint system, but it has few positive excellences of its own ; and of those few, scarcely one is remedial. The Second lesson is, that the method of providing for the insane in asylums at present pursued is faulty. It can never overtake the need for accommodation—if there be a veritable increase in the proportional number of the insane—and it deprives recent cases of the full advantages of treatment. It is, therefore, opposed to the dictates of true economy, and injurious to the welfare of the insane. These two cardinal conclusions are forced upon me by the figures and facts I have encountered in this inquiry. Others may draw different inferences from the same premises ; but, it will surprise me if the consensus of opinion founded on this research does not in principle accord with the judgment I have expressed.

If the facts are held to bear out my conclusions, so far as the limited area reviewed is concerned, I can only trust no considerations will be allowed to prevent an extension of the inquiry to a larger area, from which general deductions may be safely drawn. Should the conclusions indicated be then confirmed, it will become a duty to the public and the insane to revise the whole system of asylum treatment ; and if, as I believe will be the fact, it should appear that no effectual

reform can be effected on the present lines, prudence and policy will point to a sweeping measure of reconstruction, in which not only is the method of treatment reconstituted on a new basis, but the aid of general Medicine, and the full strength of the profession—engaged in the investigation of disease and the discovery of remedies for its relief—will be laid under contribution for the Care and Cure of the Insane.

APPENDIX.

NOTES TO REPORT, ETC., ON BROOKWOOD ASYLUM.

On the Subject of Seclusion.

Dr. Brushfield says :—

"No doubt the greater number of cases and instances of seclusion during our first year was in part attributable to the asylum being only recently opened, more difficulty being experienced in getting the attendants to settle down steadily to their work, at which most of them were novices. In part, also, the proportion was due to the character of certain cases—36 of the 49 instances occurring in a case of puerperal mania; one of the worst of its kind I ever saw. She had been treated actively with opium prior to admission; was admitted in a raving condition, to which she ultimately succumbed.

"After the first year I began to adopt a principle which had been in my mind for some time, viz. to abolish, as far as I could, ordinary seclusion. I found that there was a great deal of routine in the way in which it was ordered; and if patients became excited from *any* cause, the attendant went to the resident medical officer to report the case, and seclusion was the result. Although the usual excuse for its adoption was, that by separating the patient from the rest you placed him under circumstances tending to produce quietude, allaying excitement by removing causes of irritation, which may be the fact in a few cases, I found, on reviewing the instances, that many seclusions were for ordinary quarrelling, for a little insubordination, and for a variety of similar causes; so that, by locking up the patient, the attendant was relieved, and the patient was away from observation. I am afraid too large a number of patients have been secluded because they gave attendants trouble; if the latter could

induce the medical officer to order seclusion, a great deal of personal attention on the part of the attendant was dispensed with. 'Out of sight out of mind' is a very old motto. Now, I am no advocate for the total abolition of seclusion, believing some cases may be benefited by it, but—looking upon *ordinary* seclusion as being little better than neglect by leaving the patient to his own resources—it did not to me appear to be worthy of being called *treatment*, either medical or moral; so I determined, as far as I possibly could, to give the reverse system a fair trial, and, if patients were to be separated from their fellow-inmates, to take care that there should be no excuse on the part of the attendants for not devoting their time and attention to them, such, in fact, requiring *more* attention from the attendants than ordinary cases. I found that when the attendants saw the necessity for seclusion was disallowed by the medical officer, they soon ceased to ask for its employment. Further than this, the more intelligent of their body, particularly those having the responsible charge of the ward, were soon convinced that the patient benefited by the altered arrangement.

"On reviewing the causes or reasons for which seclusion has been employed, I find the following :—

1. For medical or surgical reasons alone.
2. For maniacal or epileptic excitement.
3. For acts of insubordination.
4. For acts of violence.
5. For ordinary quarrelling and ill-temper.
6. 'To prevent the intrusion of others' (*Twenty-eighth Report of Commissioners in Lunacy*, p. 173).

"When employed for 3, 4, and 5, the treatment cannot be called *medical*—it may be termed *moral*, perhaps; but this is, after all, I think, only another name for punishment. I can hardly understand its being employed for 6. Surely to lock a door on a patient 'to prevent the intrusion of others' argues either a lack of attendants or want of efficient arrangements for securing the proper treatment of the secluded patients. In 2, a patient with epileptic excitement should hardly be left to himself. Excitement often culminates in an epileptic paroxysm, and then there is all the liability to danger from the shirt or necktie being too tight to allow the turgid vessels of the head and neck to relieve themselves; as well as to direct suffocation from the head being buried in a mass of clothes or bedding.

"The seclusion of the cases here in 1867–70 was that of the ordinary kind, with *secured or locked* doors, according to our forty-eighth rule. The English Commissioners in Lunacy have not, since their thirteenth report (published August, 1859), given any definition or description of seclusion—what does, and what does not, fall under that head. They finish their remarks at pp. 67–8 of the report cited, thus: 'All that we desire to secure is a strict record of every instance when it is resorted to, and to prevent its being adopted, not from medical reasons, *but from*

motives of economy, and as a substitute for the watchfulness and care of properly qualified attendants.'

"At page 130 of the eighth report of the Commissioners are some valuable remarks by Mr. Cleaton, then medical superintendent of the Rainhill County Asylum, Lancashire (now one of the Commissioners in Lunacy), as to the occasional use of seclusion, in which he says, 'The best substitute for seclusion, generally speaking, appears to be outdoor occupation.'

"In a circular issued by the Scotch Commissioners in Lunacy in 1873 (their seventeenth report, page 271) is the following definition of seclusion:—'Whenever a patient is placed during the day in any room or locality, *alone and with locked doors*, the case may be viewed and recorded as one of seclusion, irrespectively altogether of the question whether seclusion was adopted for purposes of medical treatment or for purposes of discipline.' I think this is the most satisfactory *official* description that has as yet appeared.

"Now, instead of locking up an excited or other patient altogether out of the way of observation, we prefer placing one, two, or three attendants in the room with the patient, and, if the latter be much excited, to cover the floor with mattresses. The very presence of a number of attendants often allays excitement, instead of acting (as has been occasionally suggested to me) as an irritant. We diminish the number to one as soon as possible, that one having the special charge of the patient, and for the time being performing no other duty. After a time the attendant gradually withdraws his services, by sitting outside the door of the patient's room, the door being wholly or partly open—never being closed unless the patient be dozing, and even then not being secured in any way. Practically we find that but few of the cases require supervision of the latter kind, for as soon as the attendant can leave the room at all he is taken off special duty. Such is very briefly our plan, which consists simply of the patient being always kept under observation. I think the remarkable circumstance is that we have so few even of these cases. Both of my head attendants had very great opportunities of seeing the practice of ordinary seclusion elsewhere before accepting office here, and of the modified kind we employ, and they speak very positively as to the latter being the better, as it secures safety to the patient and takes away all excuse for negligence on the part of attendants."

On the Class of Cases confined in Brookwood Asylum.

Apropos the treatment, the medical superintendent says—

"We have not a very favourable class of cases to deal with, more especially as a very considerable number consists of county cases, *i.e.* of vagrants and wanderers chargeable to the county rate; and 36 are of the ex-criminal class, *i.e.* of criminal lunatics whose periods of sentence have expired. The annexed table shows 1 in every $4\frac{1}{4}$ cases to be either an epileptic or a general paralytic:—

CLASSIFICATION OF THE CASES REMAINING ON APRIL 14, 1875.

	Epileptic.	General Paralysis.	Suicidal.	Danger-ous to others.	Quiet and harmless.	Curable.	Total.	Grand Total.
Camberwell ...	10	4	16	7	7	2	46	
Lambeth	29	11	44	38	6	5	133	339
St. Olave's ...	11	9	23	28	—	2	73	
St. Saviour's	18	8	31	25	2	3	87	
Chertsey	6	2	9	13	13	2	45	
Dorking	7	—	11	8	3	2	31	
Farnham	4	—	11	1	10	3	29	
Guildford.....	11	6	14	19	10	3	63	
Hambledon ...	3	3	3	12	5	2	28	215
Windsor	—	1	6	7	1	—	15	
Croydon	1	—	—	1	—	—	2	
Godstone	—	—	1	—	—	—	1	
Epsom	—	—	1	—	—	—	1	
Out-County ...	—	3	2	1	—	1	7	7
County	3	1	17	43	22	—	86	86
	103	48	189	203	79	25	647	647
Metropolitan Unions	68	32	114	98	15	12	339	
Rural Unions	32	12	56	61	42	12	215	
Out-County ...	—	3	2	1	—	1	7	
County	3	1	17	43	22	—	86	
	103	48	189	203	79	25	647	

= 1 in every 4·28 cases.

General paralytics	Metropolitan Unions.....	1 in every	10·59 cases
	Rural Unions	1 ,,	17·91 ,,
Epileptics	Metropolitan Unions.....	1 ,,	4·98 ,,
	Rural Unions	1 ,,	6·71 ,,
General paralysis and epilepsy together	Metropolitan Unions.....	1 ,,	3·39 ,,
	Rural Unions	1 ,,	4·87 ,,

QUIET AND HARMLESS CASES.

	Removed to Caterham, 1871–75.	Remaining in Asylum.
METROPOLITAN UNIONS.		
St. Saviour's	51	2
Lambeth	21	6
Camberwell	5	7
St. Olave's.....	27	—
RURAL UNIONS.		
Chertsey.....	—	13
Dorking	—	3
Farnham	—	10
Guildford	—	10
Hambledon	—	5
Windsor.....	—	1
County Cases	—	22
	104	79

METROPOLITAN CASES—QUIET AND HARMLESS.

Removed to Caterham	104
Remaining in Asylum	15
Rural Cases	42
County Cases	22
	183

On the Proportion of Cases of General Paralysis.

Dr. Brushfield writes :—

"On examining the prevalence of general paralysis in the two asylums for Surrey from data furnished by the two reports, I found the following :—

	Wandsworth.		Brookwood.	
Cases of general paralysis—				
Remaining December 31, 1875	34	46	61	78
Died during 1875	12		17	
1. Average number of inmates in 1875	1030		669	
2. Total number on December 31st, 1875	1060		799	
3. Total number under treatment	1453		974	
One case of general paralysis in—				
1. Average number of inmates	22·4		8·5	
2. Total number on December 31	23·0		10·2	
3. Total number under treatment	31·5		12·4	

From the medical superintendent's report for 1874 I make this extract :—

"The following table shows in a striking manner the influence of this disease (general paralysis) upon the relative mortality of the two sexes in this asylum during the past year (1874), as well as for the entire period during which the institution has been occupied by the patients. It further points out the close approximation in the number of deaths in the two sexes from all other causes :—

	Deaths during 1874.		From the opening of the Asylum to December 31, 1874.	
	Males.	Females.	Males.	Females.
From general paralysis	24	2	126	15
From all other causes	23	19	153	158
	47	21	279	172

On the Subject of Cost.

"1. The average weekly cost per head includes all costs of officers and staff.

"2. To arrive at the proper cost of provisions the garden and farm expenses should be added.

"3. Wine, spirits, and porter.—The first two are each extras ; the latter is also a sick extra, and is ordered for many workers. It is the *regular* malt liquor supplied to the attendants in the majority of asylums.

"4. Possibly and probably (I have not compared them) our cost may have stood at a higher rate than the other county asylums, in this and neighbouring counties. This, if so, will be owing to our smaller number

of patients and greater *relative* cost of sundry items. For example, we had in that year (1874) 645 patients, with an average weekly cost of 10*s.* 4*d.*; with our present number of 950, our cost will be *at least* 4*d.* less, notwithstanding the increased price of various principal articles of consumption. This may be still more evident on looking at the accounts of the asylum for the city of London. The number of patients there is much smaller than at the Surrey and Middlesex asylums, and their weekly cost is *relatively* greater. The corollary to this is, that the number of patients in an asylum governs, *to a certain extent*, the cost; the greater the number the *less* the cost, and *vice versâ*."

On the Proportion of the Sexes among Lunatics.

In Dr. Brushfield's report for 1871 appears the following statement, illustrating the proportion of the sexes in relation to "the question of providing accommodation for the lunatics of a county or borough":—

"According to the last census (1871) of England and Wales, for every 1000 males, there were 1056 females. Taking Surrey by itself, the proportion of the latter sex was 1115, being 65 beyond the average, and exceeded only in four other English counties, Middlesex being at the head. Turning our attention to the insane, we find that the relative number of the females is considerably augmented, and that in this county there is a still wider disproportion in the number of the sexes.

"Of the insane of all classes in England and Wales, on January 1, 1871, the number of the males was to that of the females as 1000 to 1182; but in the pauper class alone the number of the latter sex was 1242. In this county (Surrey), on January 1 of the present year, there were 1422 females to every 1000 males; that is to say, a proportion of nearly three of the former to two of the latter. In but few counties is this proportion exceeded. On January 1, 1871, the highest proportion, 1 male to 1·52 females, was in Anglesey. In Cumberland, Durham, Rutland, and Westmoreland, the males outnumbered the females.

"The disparity in the number of the sexes in this county is well shown in the following table:—

SURREY PAUPER LUNATICS, JANUARY 1, 1872.

Where maintained.	Males.	Females.	Total.	Proportion of Sexes.	
				M. F.	M. F.
Wandsworth Asylum	399	542	941	1 to 1·35	1 to 1·31
Brookwood Asylum	295	333	628	1 to 1·12	
Government and Out-County Asylums and Licensed Houses	20	66	86	1 to 3·30	
Caterham Asylum	307	482	789	1 to 1·57	1 to 1·61
Workhouses	57	107	164	1 to 1·87	
With friends	59	86	145	.....	1 to 1·45
	1137	1616	2753	.....	1 to 1·42

"It is here shown that, with respect to the Wandsworth Asylum, the proportionate accommodation of the sexes approximates very closely to the requirements of the county. In this institution the case is very different; the relative number of the sexes resident on January 1st was

1 male to 1·12 females, but the accommodation is not in the same proportion. The building was designed for 321 males and 329 females, a proportion of 1 male to 1·02 females. To place these asylums, therefore, on the footing required by the latter, viz. 1 male to 1·42 females, an addition of 120 beds to the female division would be necessary."

NOTES TO REPORT, ETC., ON HANWELL ASYLUM.

Mr. Peeke Richards, medical superintendent of the female department, remarks on points of practical interest :—

"The evils of overcrowding, particularly excitable cases, cannot be over-estimated ; in fact, under such circumstances, a case of recovery is quite the exception.

"I constantly find that if we have a turbulent and excitable case, by removing her to another ward for even a day, she generally calms down within a very short time, and often returns to her own ward in the evening quite tranquil. One of the *advantages* of a large asylum like ours is that it enables us to shift about the patients in the manner I have described, as the removal from one part of the building to another and distant part seems to them like another world.

"The floating population of lunatics, who are constantly in and out of our asylums, is very great, not only in London, but in England generally. They are, for the most part, cases of 'recurrent mania,' and after they have been in an asylum for a month or two they become apparently well, and out they go, although one is morally certain that another attack will be sure to return sooner or later. As regards the Middlesex asylums, were it not for these cases, our vacancies would be very few. So I think that one is to a certain extent justified in discharging this class of patients, although of course there is a certain amount of risk attached to it.

"In the majority of cases, the better you dress your patients, the less prone are they to habits of destruction. Strong dresses, etc., are useful economically, but I never knew the use of them break the patient of her destructive propensities.

"The warm bath is invaluable in cases of acute mania, with a torpid skin. The shower bath should by no means be given as a *moral* measure."

The following observations are by Dr. Rayner, medical superintendent of the male department at Hanwell, and Lecturer on Psychological Medicine at Middlesex Hospital :—

Neurotic Medicines, etc.

"In the medicinal treatment of the insane I have completely

abandoned the use of the so-called neurotic medicines, which have been supposed to exercise a direct curative action on the brain.

"I am convinced that nothing can be more injurious to the brain than the continued use of drugs which act directly on it, and pervert its nutrition, which is the case with these as far as my observation goes.

"The health of the brain is best restored by improving that of the whole body, and I therefore base my treatment on the general principles that guide in diseases of other organs.

"The use of sedatives, simply to allay excitement and save trouble, is irrational and unjustifiable.

"I have reason to believe that prolonged treatment with neurotic drugs has developed the most degraded and intractable forms of insanity that our asylums contain.

Melancholia.

"In melancholia I find the use of hot baths specially indicated, both to promote the action of the skin, and to obtain sleep.

General Paralysis.

"In general paralysis the various forms of iron exert a very beneficial effect, and the diet should be very plentiful, principally fatty and farinaceous.

Epilepsy.

"In epileptic insanity, *rest* in bed after the fits avoids nearly all outbreaks of epileptic mania.

"An outbreak of mania may be induced in many cases by simply giving the patient no rest after his fits; on the other hand, those most prone to develop mania will escape if kept carefully at rest.

"I avoid the continued use of bromide of potassium, and believe that if statistics could be obtained, they would show a large increase in the number of insane epileptics since this drug came into fashion.

The Principles of Treatment.

"In the mental treatment of the insane, Bain's law of 'self-conservation' should always be borne in mind, that 'states of pleasure are connected with an increase, states of pain with an abatement, of some or all of the vital functions.'

"The 'principle' of treatment should be that of 'non-punishment' (non-restraint is a misnomer, since every patient is continuously under restraint).

"The object of treatment should be the re-development of that self-control which has been lost by disease, the means, by which the patient should be stimulated to exercise self-control, being privileges and rewards.

Seclusion.

"Seclusion I avoid as being rarely absolutely necessary, and as having a bad influence both on patients and attendants. During the past year only one man has been secluded.

"The best testimony I have in regard to this is that of my colleague, who, from being rather favourable to seclusion, has become entirely converted to my view.

"I was first led to abolish it by inquiring carefully into the origin of every case of excitement, and I soon found that by changing the patient's surroundings the excitement could generally be removed.

Employment.

"I regard employment as the greatest of remedial means, and this should be provided for every patient, even at considerable cost.

"The chronic, violent, and destructive patients of a degraded type I regard as centres of moral infection. The only way of dealing with them is to place them, one at a time, under a special attendant, to be taught to employ themselves. In this way I have succeeded in reclaiming several who were before the plague of the asylum.

"The attention and cost of an attendant, even for a whole year, is an economy in the long run.

Curability of Insanity.

"I do not entertain the unfavourable view of the curability of insanity held by many.

"I believe that under more favourable conditions than those which obtain in most asylums, a much larger proportion of permanent cures would result.

"I consider the gravest defects in our asylums to be the unskilled, untrained attendants, the imperfect arrangements for affording occupation and amusement, and the almost entire absence of effort to bring mental training to repair the mental disorder."

NOTES TO REPORT, ETC., ON COLNEY HATCH ASYLUM.

Dr. Sheppard, medical superintendent of the male department, and Professor of Psychological Medicine in King's College, has favoured me with some remarks on points of great interest. I have his permission to print the following :—

The Use of Drugs.

"With regard to treatment by drugs—'chemical restraint,' as I have on several occasions called it—I am afraid that the abuse of therapeutic agents has been very great, even by the best of us. Certainly this may be said of opium to a very notable extent. The old cry was that opium was our 'sheet-anchor' in the treatment of insanity, and that every form of the disease required its adoption. There never was a greater fallacy. In all cases of acute mania it complicates, and therefore aggra-

vates, our difficulties. It stupefies, in very large doses, without producing sleep, and increases that hyperæmic condition of the cerebrum and its investing membranes to which the symptoms are commonly due. Digitalis is much more efficacious in all maniacal disturbances unassociated with prostration and feebleness; and the effect of this drug in toning down the ecstatic and emotional excitement so common in the first and second stages of general paralysis is very marked. The best preparation of opium that I am acquainted with is *Squire's Liq. Morph. Bimeconat.* From 30 to 50 minims, or even more, with ʒss. of the hydrate of chloral at night, in all cases where persistent sleeplessness is dependent upon nervous exhaustion, constitute a very valuable hypnotic. The same is also useful in those cases of melancholia so commonly bordering on hypochrondriasis, when there is intense irritability of the entire sympathetic system and a sensation of disarrangement of the gastric apparatus. Chloral, by itself, is a very valuable remedy, but it does not meet the sleeplessness and turbulence of acute mania. In every other wakeful condition it has an almost unfailing power. All, I need scarcely say, are not equally tolerant of it, and there are idiosyncrasies which make it necessary for the physician to watch carefully its effects. It is to be hoped that the abuse of this pleasant drug by the neuralgic and hypochondriacal will not bring it into disrepute. I have heard that already some alienist physicians are beginning to exclude it from their remedial category. I have little or no faith in tartar emetic or cannabis Indica. The bromide of potassium sometimes exercises a marked control (ʒss. doses) over maniacal delirium, even when the delirium is not associated with epilepsy. Purgatives are always useful when there is foulness of tongue and fetor of breath, and their action paves the way for, and commonly insures, the efficacy of hypnotics—just as a saddle of mutton or a grouse at the epicure's table invites the sequence of a beaker of Burgundy.

Untrustworthy Statements by Friends.

"In nineteen cases out of twenty the stories told by the certificates on which patients are admitted into pauper county asylums are unreliable and worthless. The certificates, in fact, are formulated fallacies. The statistical tables, therefore, which are appended to our annual reports are of no value. The blunder arises in this way. A patient is taken to the workhouse, supposed to be insane. He is there, say, for a week, and gets worse and unmanageable. Arrangements are made by the workhouse authorities for sending him to the county asylum, and the details of age, sex, cause, time insane, etc., are filled in, to save time, before the medical officer takes any action. The 'time insane' is generally given as coincident with the time the patient has been in the workhouse, and 'one week' will be written down against a person in the second or even third stage of general paralysis. When the friends come down to the asylum, they confirm the error which, of course, the medical superintendent has already detected. But even the statement of friends is often unreliable, and it is only upon pressure that they will admit a long retrospect of

strange conduct, believing that the insanity has commenced with the more recent outbreak of violence which made removal to the workhouse necessary.

Early Treatment.

"The importance of early treatment is not to be over-estimated ; but the difficulty of persuading friends that any treatment is necessary is very great.

"I have great faith in the wet sheet. In the summer time I use it frequently. Shower baths are no less valuable aids ; and frequently, in cases of mania, I use the warm bath at night, with cold affusions to the head—this in cases of noisy and persistent insomnia. The value of the Turkish bath cannot be overstated—notably in melancholia, and during the convalescence from mania.

Epilepsy.

"As a rule, epileptics are the most dangerous, impulsive, and unreliable of all lunatics. It is obvious that the facility of watching them must be in the ratio of your power to associate them in one dormitory. It is not fair to non-epileptic patients to scatter epileptics among them in associated rooms, and it is unsafe to put a number of epileptics together in one room. This, because they are given so much to excitement and foolish acts before their characteristic convulsions, that one patient may disturb a whole dormitory in the course of a few minutes. Their great requirement, therefore, is single rooms. But the structural expense of our county asylums is so increased by a number of single rooms that we are unable to get all we want. We are compelled, therefore, to associate the most harmless, and isolate the most dangerous. This isolation must be complete ; each single room must be a single room in the real sense of the expression, and not a mere division of one chamber into stalls open at the top, the lateral elevation of each stall being perhaps four feet, for what is called complete inspection *en masse* by the night-watch. I believe, therefore, that the only real security, from themselves and from others, of dangerous epileptics lies in single visitation, *i.e.* in frequent (say, every hour) inspection of each dormitory. There is an obvious objection to this. The unlocking and relocking disturbs and irritates, and complaints are often made about it by the patients themselves ; but by doing this many an epileptic is saved from asphyxia by turning his face upon the pillow during a fit. I have the majority of my epileptics as near the head-quarters of the chief night-watch as possible ; he knows those who are given to turn on their faces, and he knows the varied sounds and the thick breathing which precede and accompany the seizure. It is very rarely that I have a patient suffocated—not once in two years. This is saying a great deal, and, as I take it, is an evidence of our watchfulness. It is worthy of note that many epileptics, both by day and night, are most indignant at being scrutinized and watched too closely. They protest in the strongest language, and are impressed with the most intense belief, that they never had a fit in their lives. *Hinc illæ lachrymæ !*

Seclusion and Restraint.

"If the history of medicine did not furnish many instances of the rushing from one extreme of treatment to its opposite, it would be almost incredible that any physician of large experience in the treatment of the insane should affirm that exceptional seclusion and restraint are not at times both salutary and humane.

"The unfortunate abuse of these agents in days gone by, their almost universal application in troublesome cases as a means of speedily relieving, not the patient, but his attendant, have of course very naturally prejudiced the public mind against them. But at the right moment and in the right case, seclusion is an heroic remedy which exercises a speedy and beneficial effect. There are two things to be considered in its adoption: first, the effect it may have upon the patient himself; second, the security it affords to those about him. There are no cases so difficult to deal with as those in which periodical mania is associated with epilepsy. Their aggressive character is frequently of the most furious and ungovernable kind. To attempt to reason with such patients, or to give medicine to such patients, is absolutely childish. Nothing is safe from their onslaught, and their personal animosity is of the most intense kind. By placing them in a padded room we minimize external exciting causes; we lessen the general uproar which this convulsive explosion produces; we give security to other patients, and obviate the necessity for more than one summary struggle between the attendants and the patient himself. It is quite an exceptional thing to notice anything but a feeling of satisfaction on the part of the other patients, when a person of this kind is disposed of for the time being by seclusion; and ready help is given to the attendants, in effecting this step, by other epileptics themselves. There is another reason why seclusion is good for epileptics of this class, and that is on account of the frightful screaming in which they frequently indulge. A padded room deadens the sound, and therefore lessens the irritation produced upon others by a continuous roar.

"If we take a case of acute mania, uncomplicated with epilepsy, in which the tendency to aggression, destructiveness, self-denudation is very marked, the desirableness of temporary seclusion is scarcely less apparent. The brain irritation is intense; all external objects are sources of provocation and annoyance. Here darkness and solitude are essentially a medical need, which no observant physician should fail to recognize. Nay, in many chronic cases, associated with paroxysmal excitement, the patients themselves recognize this need, and ask for the retreat of solitude and the absence of light. It is impossible to shut one's eyes to the important teaching of such a fact as this. Is the surgeon regarded as cruel who darkens the chamber of his patient who is suffering from iritis?

"There is another class of patients with whom the question of seclusion becomes a more difficult matter. In all large county asylums there are a number of persons in whom a minimum of insanity is associated with

a maximum of vice. We are called upon by the lunacy laws to treat this minimum, and to ignore this maximum. These subjects destroy order, provoke insubordination, organize sedition, tyrannize over their weaker brethren, assault attendants, daring them to resentment, because they (the aggressors) are certified lunatics and claim protection from the law. No one who has not had experience of it knows the difficulties which beset a medical superintendent and his staff in the management of cases of this kind. It is all very fine for outsiders to say that the treatment of the insane should never assimilate to anything of a punitive kind or character; but with men and women of the stamp alluded to, a padded room is an object of fear and terror, because it incapacitates them for the time from mischief, when their mischief is just culminating in some act of aggression or attempt to escape. Here seclusion is not a medical application to an excited brain, but a moral subjugation of a bad heart, affecting not only the individual but the class. The moral effect produced in the cases above alluded to, lies in showing that you have the power and the capacity to execute. Five minutes, therefore, may do all you want to do; produce a moral shock, an electrical discharge, and then your patient is a free man again, and powerless.

"Concerning restraint I have little to say. It should be obvious to every intelligent person that in surgical cases it is often needed for self-protection. Fastening the hands by a strap to the side of the dress is a humane thing to do to a man who is so mad that he pulls all the hair off his scalp, or blacks his own eyes by repeated pummelling. So, also, in cases of determined suicidal tendency it is sometimes desirable; and, dreading the access of an uncontrollable impulse to self-destruction, patients have often asked me to restrain them.

"The worst and most unreliable form of restraint that I know of is the putting one or two men or women to supervise and control a dangerous and aggressive lunatic.

"I should be sorry to speak, and I do not mean to speak, disrespectfully of my brother superintendents, who, for the most part, are doing a great work in a manly and conscientious manner. But I cannot help thinking that some of them, when called upon to treat a difficult case, where the propriety of restraint may be involved, are awed into the negative course by the dread of an inevitable entry in the *Medical Journal*. They forget (to quote the words of the greatest of American psychologists, Dr. Isaac Ray) that the object in view should be, 'not to promote a little national jubilation over the success of a theory, but the highest welfare of the particular individual patient.'

"To my heathen mind, the fact that asylums may be conducted, and *are* conducted, without either restraint or seclusion, is no evidence that they *should* be so conducted. And it is a circumstance of no mean significance in my experience at Colney Hatch that, in cases of transfer from other asylums to this, the patients' complaints of ill-treatment have always been loudest and most unmistakable against those institutions where it is a matter of boast that seclusion and restraint are never resorted to. The difficulty—nay, impossibility—of obtaining attendants who can

exercise complete control over their tempers and their hands, under the ceaseless provocations to which they are sometimes exposed in 'special' cases, makes me feel more strongly every day that what have been stigmatized as the *opprobria* of asylum management (seclusion and restraint) may often be a real repose and tranquillity to a struggling 'special,' and largely promote his immediate and ultimate welfare.

"One thing is quite certain, and that is that (again to quote Dr. Ray) this matter of restraint or non-restraint 'is a scientific question, to be studied and discussed in the spirit of a strictly scientific inquiry; and our conclusions, whatever they may be, should furnish no occasion for excited feeling, nor assumptions of superior skill or humanity.'"

Unfit Cases.

The following passages appear in Dr. Sheppard's report for 1876:—

"Again it is my duty to state that a considerable number of infirm and feeble old men are brought to the asylum to run through a brief course of 'second childishness and mere oblivion,' which might be equally sustained with a little extra care and vigilance on the part of the workhouse authorities in the infirmary wards which they supervise and administer. Twelve patients over 70 years of age, and many others absolutely younger but prematurely senile, might well have been included in this category. So, again, feeble and bed-ridden dements of all ages are transferred to us, to linger out the few weeks of life that nature has assigned to them; and the only reason that we discover for their perilous removal from the workhouse to the asylums is that they are occasionally a little noisy at night. We need some legislative protection against this abuse of the county lunatic asylums.

Intemperance and Insanity.

Dr. Sheppard has in his "Lectures on Madness," already quoted, the following admirable and, looking to the importunate platform aspect of this grave question, most opportune summary of opinions on the subject of "Drink" as one of "physical causes of insanity":—

"Without doubt the most frequent of these is *intemperance*. Considering the unreliability of statistics, to which I have before alluded, it is not easy to measure with perfect accuracy the extent of this evil as a causal phenomenon. Every additional year of experience confirms me in the belief that it is filling our madhouses with its subjects. I cannot tell you by it how many homes are broken up—how many hearts are broken down. It is a gigantic misery, parturient of evil, committing its terrible havoc not only upon the first, but upon 'the third and fourth generations of them that hate Me.'

"Yet it is to be noticed that even here an element of great uncertainty is introduced. A renowned French psychologist (M. Moreau) says, 'Drunkenness is regarded as one of the most frequent causes of insanity. But it is equally certain that drunkenness, or rather *the taste for drink*, is as often, and even more frequently, a first symptom (the effect, therefore, and not the cause) of disease.' And this taste, he affirms, has been

hereditarily transmitted from the parents to their offspring, just as the same features and gait, and colour of hair, and complexion. 'I receive patients daily at the Bicêtre,' the same author wrote, 'in whom I can trace back the origin of their malady to nothing else but the habitual intoxication of their parents.' These words actually express my own experience at Colney Hatch Asylum. Esquirol long since gave utterance also to something like the same truth when he wrote—'If the abuse of alcoholic liquors is an effect of mental depravity, of educational vices, and the force of bad example, men sometimes give way to it by reason of a morbid impulse which they have not the power of resisting.' Another French psychologist (Morel) also observes : 'It is not necessary to create a monomania of which the chief characteristic is an irresistible tendency to fermented liquors. This tendency is most frequently only the *symptom* of a principal disease, especially when it is suddenly developed in persons who had previously given no evidence of such a propensity.'

"Dr. Anstie, who has made alcoholism a special study, is clearly of opinion that, of all depressing agencies, it has 'the most decided power to impress the nervous centre of a progenitor with a neurotic type, which will necessarily be transmitted, under varied forms and with increasing fatality, to his descendants.' A large-hearted essayist and divine of our own day (Canon Kingsley) has also written, 'I am one of those who cannot on scientific grounds consider drunkenness as a cause of evil, but as an effect. Of course it is a cause—a cause of endless crime and misery ; but I am convinced that to cure you must inquire, not what it causes, but what causes it.'

"You see, then," continues Dr. Sheppard, "that this subject, in its etiological bearing, is invested with very much uncertainty. The immediate effects of drink are sufficiently obvious, but its ulterior effects are intricate and far-reaching, while the ancestral antecedents of the intemperate may create for them many excuses and entitle them to much sympathy."

In his report for 1876, Dr. Sheppard says :—

"It is painful again to allude to the large part which alcoholic intemperance plays in the production of insanity. A careful analysis of the history of the year's admissions clearly establishes a percentage of more than 28 as due to this cause. And I am persuaded, from the character of the individuals and the form of their malady, in other cases where the causation is not assigned or cannot accurately be traced, that an addition of 12 per cent. may directly or indirectly be attached to the same origin. Thus we have an approximate record of 40 per cent. of the madness of Middlesex as due to an avoidable cause—and that cause the growing passion for drink."

NOTES TO REPORT, ETC., ON "METROPOLITAN DISTRICT ASYLUMS."

The following paragraphs are from the report of Dr. Shaw, medical superintendent of the institution at Leavesden (1876):—

"Seclusion has been resorted to chiefly for patients who have since been removed to the county asylum. The instances have not been numerous, however, and have been recorded in the book kept for the purpose. The circumstances necessitating seclusion are so different in various cases, according to the nature of the building, the grouping of the patients, the various opinions held by medical men on the subject, and the disposition of the attendants, that it is useless to specify the number of occasions and of hours during which it has been enforced, unless (which is out of the question in a report of this nature) a minute account of the circumstances and surroundings of each case could be given. Though I resort to seclusion when I consider it necessary, I can yet quite conceive others carrying on an asylum without it, though I should hesitate to characterize such as the perfection of treatment, except in peculiarly constituted insane populations."

The populations of Leavesden and Caterham are, of course, "peculiarly constituted" (see remarks of Dr. Adam on seclusion further on).

"Of the imbecile class proper, of which at the first we received so many, few are now sent, whilst the number of general paralytics has largely increased. It is worth remarking that many of our imbecile, patients have been (more in proportion than any other class) in prison, thus confirming the opinion now universally held, that crime and mental defect are usually associated. The improved certificates of admission, which have been some time in use, have had the effect of calling the attention of the certifying medical officer more strictly to the mental condition of the patients, with the very good result that now, with scarcely an exception, patients sent here do without doubt suffer from distinct mental symptoms, and it has been necessary in only four instances during the last two years to return persons as 'not insane' to the parishes."

The Lancet report on this workhouse asylum is thus commented upon:—

"I would take this opportunity of referring to the remarks made by *The Lancet* commissioner, in his official report on this asylum, because, having never yet been openly contradicted, they might lead to false opinions. It is not true, as *The Lancet* observes, that any are here for whom a certificate of insanity could not be given. It is not, to my mind, sufficient for mere senile decay to constitute a qualification for admission here; there must be in addition some mental defect, be it the presence of hallucination or delusion, restlessness, or any other of the infirmities rendering special protection necessary. Neither do I agree with the view

taken by the commissioner, that the medical superintendentship is merely a nominal matter, and that it implies simply a medical officership. It must be remembered that there are two views held as to the expediency, or otherwise, of making the medical man exercise other functions than his medical ones—such, I mean, as the stewardship, engineering, and so on. I am bound to say that personally I should be sorry to delegate the strictly medical work of an asylum to others in favour of taking the lay responsibility myself, for I take it that the function of a medical man in an asylum is very like that of a physician to an hospital, and I should no more expect to see disrespect, loss of position, or insubordination in the one case than I should in the other, where lay work is never dreamt of. It appears to me that in an asylum of upwards of 2000 patients, there is no time for much beyond the pure medical work of the place, and however good the assistants of such an establishment may be, there is still enough for the responsible medical authority to do to keep *au courant* with the numberless medical incidents that occur hourly in the midst of so large an impaired population. I must do the committee the justice to say that they exactly appreciate the object of an institution of this kind, which is not the glorification of one man, but the welfare of a much-to-be-pitied class of persons, and that they do everything in their power to support measures (which in the end come to be medical) conducive to the main object. In any difficulty I have always appealed to them, and have been uniformly treated with courtesy and consideration, no reasonable request being refused, whilst the responsibility of a doubtful matter has been taken off my hands. If my views run counter to those of some of my professional *confrères*, I can only say that I am speaking of my own individual experience on what is a public question, and that whilst stating this, as in duty bound, I can quite see that there are asylums of such a character that the other view of the question may be reasonably taken. Administration, medical treatment, the combination of the lay and professional elements, the peculiarities of patients as modified by different conditions of place and temperament, etc., are too subtle and intricate to be generalized upon ; all I would say is that the present state of things at Leavesden (the combination of those exercising distinct functions may be a fortuitous one) is such as I believe works best in the interests of the patients and ratepayers."

The question of fact is answered by the report of the Commissioners in Lunacy, and, so far as I am concerned, my own judgment of the patients seen at my visit. The question of policy in regard to organization, and the position of a medical superintendent at an asylum for the insane, is discussed at length in my work. In *The Lancet* report on these asylums —which are "*workhouses* within the meaning of the Act"—I was careful to say it did not seem indispensable, perhaps scarcely desirable, looking to the personal interests of a physician labouring to make bricks without straw—cures without curable cases—to give the chief medical officer responsible control.

The following is from a paper "On Uncontrollable Impulse," by

Dr. T. Claye Shaw, who has been appointed medical superintendent of the third asylum for Middlesex at Banstead. The article will be found in St. Bartholomew's Hospital Reports, vol. xi. :—"Most children, whose brains are imperfectly developed, exhibit impulses for which they can give no reason; they will tear their dolls up or break furniture, and then become calm after the act of destruction; also, at the critical periods when the circulation in the brain and other viscera is much deranged, the same thing is seen. When, in the various stages of decay in the upper cerebral centres, there comes what Professor Laycock (in his recent able article in the 'Journal of Mental Science') calls the period of 'synetic reversion,' the mind reverts to what it was, impulses become stronger, and at last irresistible. Will may be termed the slowing-power that regulates other cerebral processes; it is not developed till late, sometimes never at all, and in decay it is seen to be the first faculty to go. The knowledge of right and wrong, the knowledge of consequences of any act, are within the compass of brains far inferior to man's in point of development; and even though it may be acknowledged that in some of the lower animals there is a certain amount of will shown, so that, *e.g.*, a dog will not do from will (evoked, perhaps, by terror of the consequences) what he knows is against his precepts, yet here it must be remembered that, so far as it goes, the brain in question is a healthy one. That the will is never in any one a fully perfected faculty is palpable without demonstration."

Dr. Adam, medical superintendent of the similar establishment at Caterham, in his report for 1876, says—

"There has been a gradual falling off in the number of admissions during the last three years, and it has continued this year. In 1874, 504 patients were admitted; in 1875, 486; and now the further diminution has taken place to 385. The cause of this I cannot presume to state definitely with confidence, but it may be that a class of cases which for a time were considered fit for treatment in this asylum, are with further experience found to be more suitably detained and treated elsewhere. The chronic and imbecile cases also, which had, previously to the erection of the metropolitan asylums, accumulated in large numbers in workhouses, were, after the opening of these asylums, gradually sent, and the supply is probably now becoming exhausted; or there may be greater pecuniary inducements to the authorities of the various unions and parishes, in consideration of the capitation grant, to remove their mentally diseased patients to the county asylums.

"Incurability, either from advanced organic disease of the brain, from congenital deficiency or malformation, continues to be the chief mental characteristic of those admitted. . . . . Whilst this can be said of the mental, the physical and bodily condition may, in a very large number of cases, be described as deplorable in the extreme. Many are carried or assisted from the conveyance which brings them from London into the infirmary wards of the asylum, which are the only fit receptacles for them (and on the space of which there is always undue

pressure), and where for a longer or shorter time they linger, and then die. The large proportion of deaths which I have previously mentioned, viz., more than a third of the total admissions from the opening of the asylum, is the best proof of the condition of those admitted."

The following relates to the subject of seclusion :—

"Once more I have to report that another year has passed without its being necessary to resort to the use of mechanical restraint ; and this year, as well as for several years past, it has been found quite possible, and the patients have been managed, without the use of seclusion."

Dr. Adam has favoured me with the following additional remarks :—

"It may be said that the character of the patients resident in the metropolitan district asylums is such as should not necessitate such a measure ; but when it is considered how large a proportion of them are the subjects of epilepsy, combined with insanity and general paresis of the insane—these being generally acknowledged as, of all classes of the mentally unsound, perhaps the most prone to sudden and impulsive excitement—and that of the remainder a very large number are in a chronically maniacal state with delusion, it will be seen that, at all events, the elements for excitement are not wanting.

"Whilst decrying the too ready use of seclusion, and desiring that it should be looked upon as exceptional treatment, I should not hesitate to use either that or separate treatment in any case requiring it ; but I believe that those cases might be reduced to a minimum. There is always a risk of the abuse of seclusion, for the attendant is apt to find, if he is allowed to use it indiscriminately (only reporting when he does so), that there are many cases he will be unable to manage without it. Constant medical supervision and treatment—intimate personal knowledge of the mental peculiarities, physical and bodily condition, of individual cases—the proper selection and number of attendants—with cheerful surroundings and appropriate diet, will in my opinion tend always to great reduction, or even total abolition, of seclusion."

DIET SCALES.

I GIVE the Diet Lists in force during the year 1874 at the several Asylums, Hospitals, and "Workhouses" Asylums for Imbeciles, visited, as they stand in the returns made to the Justices and Governors, or have been supplied to me by the Medical Superintendents, in the order of the reports printed in this and the preceding volume.

SURREY COUNTY LUNATIC - - ASYLUM, BROOKWOOD.

(*From the - - Report for* 1874.)

DIET - - SCALES.

DAYS.		Bread.		Meat.		Potatoes. Peeled.		Potatoes. Unpeeled.	
		M.	F.	M.	F.	M.	F.	M.	F.
		oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz
Sunday	Roast Meat	16	12	7	6	12	10	...	...
Monday	Boiled Meat	16	12	7	6	...	...	16	12
Tuesday	Irish Stew	16	13	2	2	16	12	...	...
Wednesday	Meat Pie	15	12	5	4	6	4	...	...
Thursday	Boiled Meat	16	12	7	6	...	...	16	12
Friday	Soup	12	10	2	2	...	...	...	...
Saturday	Meat Pie	15	12	6	5	6	4	...	...
Weekly Total		106	83	36	31	40	30	32	24

Flour.		Peas.		Rice.		P. Barley.		Carrots.		Onions.		Turnips.		Suet or Dripping.	
M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.
...	...	...	...	...	...	...	...	...	...	1½	1½	...	...	...	...
...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
...	...	...	...	...	...	...	...	1½	1½	1½	1½	1½	1½	...	...
4½	3½	...	...	1½	1½	...	...	...	...	...	...	...	...	1½	1
...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
8	6	1¾	1¾	¾	¾	½	½	1¾	1¾	⅞	⅞	...	...	1½	1
4½	3½	...	...	1½	1½	...	...	...	...	...	...	...	...	1½	1
17	13	1¾	1¾	3¾	3¾	½	½	3	3	3⅜	3⅜	1½	1½	4½	3

EXTRA FOR - - - WORKERS.

Males.—4 oz. Bread, 1 oz. Cheese, ½ pint Beer, daily.

Females.—9 oz. Bread, 1 oz. Cheese, ½ pint Beer, daily.

DAYS.	BREAKFAST. MALES.			BREAKFAST. FEMALES.			DINNER. MALES.						
	Bread.	Butter.	Cocoa.	Bread.	Butter.	Cocoa.	Uncooked Meat.	Irish Stew.	Soup.	Meat Pie.	Vegetables.	Bread or Dumpling.	Beer.
	oz.	oz.	pints.	oz.	oz.	pints.	oz.	pints.	pints.	oz.	oz.	oz.	pints.
Sunday	6	½	1	5	⅓	1	7	...	...	...	12	4	½
Monday	6	⅓	1	5	⅓	1	7	...	...	...	16	4	½
Tuesday	6	⅓	1	5	⅓	1	2	1½	...	...	16	4	½
Wednesday	6	⅓	1	5	⅓	1	5	...	...	16	6	3	½
Thursday	6	⅓	1	5	⅓	1	7	...	...	...	16	4	½
Friday	6	⅓	1	5	⅓	1	2	...	1½	...	...	16	½
Saturday	6	½	1	5	⅓	1	6	...	...	16	6	3	½
Weekly Total	42	2⅓	7	35	2⅓	7	36	1½	1½	32	72	38	3½

DINNER. FEMALES.							SUPPER. MALES.				SUPPER. FEMALES.			
Uncooked Meat.	Irish Stew.	Soup.	Meat Pie.	Vegetables.	Bread or Dumpling.	Beer.	Bread.	Seed Cake.	Butter.	Tea.	Bread.	Seed Cake.	Butter.	Tea.
oz.	pints.	pints.	oz.	oz.	oz.	pints.	oz.	oz.	oz.	pints.	oz.	oz.	oz.	pints.
6	...	...	...	10	2	⅓	...	6	...	1	...	5	...	1
6	...	...	...	12	2	⅓	6	...	⅓	1	5	...	⅓	1
2	1	...	...	12	3	⅓	6	...	⅓	1	5	...	⅓	1
4	...	...	12	4	2	⅓	...	6	...	1	...	5	...	1
6	..	...	...	12	2	⅓	6	...	⅓	1	5	...	⅓	1
2	...	1	...	...	12	⅓	6	...	⅓	1	5	...	⅓	1
5	...	...	12	4	2	⅓	6	...	⅓	1	5	...	⅓	1
31	1	1	24	54	25	2⅓	30	12	1⅔	7	25	10	1⅔	7
							42				35			

Tobacco and Snuff given as indulgences to the patients who are employed in field work, etc., and to other patients by order of the Medical Superintendent.

The Extra Diets, as per Summary of Sick Lists, consist of Mince Meat, Bread, Beef Tea, Mutton Chops, Beef Steaks, Bacon, Eggs, Light Puddings, Green Vegetables, Arrowroot, Tea, Coffee, Milk, Porter, Wine, Brandy, Gin, etc., etc.

Cocoa for 100 Patients.
3¼ lbs. Cocoa.
6½ ,, Treacle
3 gals. Milk.

Tea for 100 Patients.
1 lb. Tea.
4 ,, Sugar.
2 gals. Milk.

Coffee for 100 Patients.
1½ lbs. Coffee and ¼ lb. Chicory.
4 ,, Sugar.
2 gals. Milk.

Meat Pies—1 lb. to each male patient, and 12 oz. to each female patient. Suet Dumplings—1 lb. to Males, and 12 oz. to females on Soup days (Fridays). Soup consists of the liquor of the Boiled Meat of the previous day, Bones, etc., with Meat, 12 lbs.; Peas, 5 lbs.; Rice, 1½ lb.; Pearl Barley, 12 lbs.; Carrots, 6 lbs. Onions, Spice, etc., for 100 patients. Fruit Pies are substituted for Meat when Fruit is in Season.

Mince Meat Diets consist of 6 oz. Cooked Meat for males, 5 oz. for females, ⅜ lb. Peeled Potatoes, 1 oz. Rice, and 3 oz. Bread, each. Cake made from the dough for Bread, with the addition of 6½ lbs. Dripping, 2½ lbs. Sugar, and ⅞ lb. Carraway Seeds, per 100 patients.

Fish—1¼ lb. to males, 1 lb. to females.

MIDDLESEX COUNTY LUNATIC

(*From the - - -*

DIET TABLE FOR

	BREAKFAST.						LUNCHEON.						DINNER.		
	MALES.			FEMALES.			MALES.			FEMALES.			MALES.		
	Cocoa.	Bread.	Butter.	Tea.	Bread.	Butter.	Bread.	Cheese.	Beer.	Bread.	Cheese.	Beer.	Cooked Meat, free from bone.	Fish.	Pie.
	pint.	oz.	oz.	pt.	oz.	oz.	oz.	oz.	pt.	oz.	oz.	pt.	oz.	oz.	oz.
Sunday	1	6	½	1	5	½	3	1	½	3	1	½	5	...	...
Monday	1	6	½	1	5	½	3	1	½	3	1	½	5	...	...
Tuesday	1	6	½	1	5	½	3	1	½	3	1	½	5	...	...
Wednesday	1	6	½	1	5	½	3	1	½	3	1	½	3	...	4
Thursday	1	6	½	1	5	½	3	1	½	3	1	½	...	10	...
Friday	1	6	½	1	5	½	3	1	½	3	1	½	5	...	...
Saturday	1	6	½	1	5	½	3	1	½	3	1	½	2	...	...
Total ...	7	42	3½	7	35	3½	21	7	3½	21	7	3½	25	10	4

DINNER—MALE PATIENTS.

Sunday .....Roast Pork, Beef, or Mutton.
Monday .....Boiled Bacon or Pickled Pork.
Tuesday .....Boiled Australian Beef or Mutton.
Wednesday ...Meat Pies.
Thursday ...Fish, fried or boiled, with Melted Butter.
Friday .....Boiled Bacon or Pickled Pork.
Saturday ...Irish Stew.

DIET TABLE FOR

	BREAKFAST.						DINNER.					
	MALES.			FEMALES.			MALES.					
	Cocoa.	Bread.	Butter.	Tea.	Bread.	Butter.	Cooked Meat, free from bone.	Soup.	Fish.	Pie.	Stew.	Vegetables.
	pint.	oz.	oz.	pint.	oz.	oz.	oz.	pint.	oz.	oz.	oz.	oz.
Sunday	1	6	½	1	5	½	5	...	...	...	...	9
Monday.....	1	6	½	1	5	½	2	1	...	...	...	...
Tuesday.....	1	6	½	1	5	½	5	...	...	...	...	9
Wednesday ...	1	6	½	1	5	½	3	...	...	4	...	12
Thursday	1	6	½	1	5	½	...	...	10	...	...	9
Friday	1	6	½	1	5	½	5	...	...	...	...	16
Saturday	1	6	½	1	5	½	2	...	...	...	16	...
Total ...	7	42	3½	7	35	3½	22	1	10	4	16	55

DINNER—MALE PATIENTS.

Sunday .....Roast Pork, Beef, or Mutton.
Monday .....Soup, thickened with Oatmeal, Rice, and Peas, and containing 2 oz. Meat for each patient, with a proportion of Ramornie Extract; also 8 oz. Suet Pudding, or 10 oz. Baked Rice Pudding.
Tuesday .....Boi'ed Australian Beef or Mutton.
Wednesday...Meat Pies.
Thursday ...Fish, fried or boiled, with Melted Butter.
Friday .....Boiled Bacon or Pickled Pork.
Saturday .....Irish Stew.

2 oz. of Cheese and ½ pint Beer given to the male patients for Supper, in lieu of 1 pint Tea and ½ oz. Butter, if requested.

For 1 pint of Cocoa—½ oz. Cocoa, 1 oz. Treacle, and ½ of a pint of Milk.
For 1 pint of Tea—½ oz. Tea, ½ oz. Sugar, and ½ of a pint of Milk.
Irish Stew—liquor of the Meat cooked the previous day, with 2 oz. cooked Australian Meat, and a proportion of Ramornie Extract, with 12 oz. Vegetables for each patient

- - - ASYLUM, HANWELL.

Report for 1874.)

PATIENTS EMPLOYED.

DINNER.												SUPPER.					
MALES.					FEMALES.							MALES.			FEMALES.		
Stew.	Vegetables.	Bread.	Dumplings.	Beer.	Cooked Meat, free from bone.	Fish.	Pie.	Stew.	Vegetables.	Bread.	Beer.	Tea.	Bread.	Butter.	Tea.	Bread.	Butter.
oz.	oz.	oz.	oz.	pt.	oz.	oz.	oz.	oz.	oz.	oz.	pt.	pint.	oz.	oz.	pint.	oz.	oz.
...	9	3	...	½	4	...	...	...	8	3	½	1	6	½	1	5	½
...	16	3	...	½	4	...	...	...	12	3	½	1	6	½	1	5	½
...	9	...	4	½	4	...	...	...	12	3	½	1	6	½	1	5	½
...	12	...	...	½	3	...	4	...	12	...	½	1	6	½	1	5	½
...	9	3	...	½	4	...	...	...	8	3	½	1	6	½	1	5	½
...	16	...	4	½	...	8	...	...	8	3	½	1	6	½	1	5	½
16	...	6	...	½	2	...	...	16	...	4	½	1	6	½	1	5	½
16	71	15	8	3½	21	8	4	16	60	19	3½	7	42	3½	7	35	1¾

DINNER—FEMALE PATIENTS.

Sunday .....Roast Pork, Beef, or Mutton.
Monday .....Boiled Bacon or Pickled Pork.
Tuesday .....Boiled Beef or Mutton.
Wednesday ...Meat Pies.
Thursday ...Boiled Australian Beef or Mutton.
Friday .....Fish, fried or boiled, with Melted Butter.
Saturday ...Irish Stew.

PATIENTS NOT EMPLOYED.

DINNER.										SUPPER.					
MALES.			FEMALES.							MALES.			FEMALES.		
Bread.	Dumplings.	Beer.	Cooked Meat, free from bone.	Soup.	Fish.	Pie.	Stew.	Vegetables.	Bread.	Beer.	Tea.	Bread.	Butter.	Tea.	Bread.	Butter.
oz.	oz.	pint.	oz.	pint.	oz.	oz.	oz.	oz.	oz.	pint.	pt.	oz.	oz.	pt.	oz.	oz.
3	...	½	4	...	...	...	...	8	3	½	1	6	½	1	5	½
6	...	½	2	1	...	...	...	...	4	½	1	6	½	1	5	½
...	4	½	4	...	...	...	...	12	3	½	1	6	½	1	5	½
...	...	½	3	...	...	4	...	12	...	½	1	6	½	1	5	½
3	...	½	4	...	...	...	...	8	3	½	1	6	½	1	5	½
...	4	½	...	...	8	...	...	8	3	½	1	6	½	1	5	½
6	...	½	2	...	...	...	16	...	4	½	1	6	½	1	5	½
18	8	3½	19	1	8	4	16	48	20	3½	7	42	3½	7	35	1¾

DINNER—FEMALE PATIENTS.

Sunday .....Roast Pork, Beef, or Mutton.
Monday .....Soup, thickened with Oatmeal, Rice, and Peas, and containing 2 oz. Meat for each patient, with a proportion of Ramornie Extract; also 8 oz. Suet Pudding, or 10 oz. Baked Rice Pudding.
Tuesday .....Boiled Bacon or Pickled Pork.
Wednesday ...Meat Pies.
Thursday ...Boiled Australian Beef or Mutton.
Friday .....Fish, fried or boiled, with Melted Butter.
Saturday ...Irish Stew.

...

Currant Dumplings (made with Dripping or Suet) are given every third Saturday, in lieu of Stew, 12 oz. to the males, and 11 oz. to the females. ½ pint Beer at 4 p.m., and Tobacco and Snuff, for working patients.

MIDDLESEX COUNTY LUNATIC ASYLUM, COLNEY HATCH.

(*From the Report for* 1874.)

DIET TABLE.

MALES.

BREAKFAST	... ...	6 oz. Bread and ½-oz. Butter. 1 pint Cocoa.
DINNER	TUESDAY	13 oz. Pie (containing 4 oz. Meat). 9 oz. Vegetables. ½ pint Beer.
	MONDAY, THURSDAY, FRIDAY, SUNDAY	5 oz. Cooked Meat. 9 oz. Vegetables. 4 oz. Bread. ½ pint Beer.
	WEDNESDAY	1 pint Stew and 6 oz. Bread, as on Saturday. *or* 9 oz. Fish. 9 oz. Vegetables. 4 oz. Bread. ½-pint Beer (with either Dinner).
	SATURDAY	1 pint Irish Stew, made with 3 oz. Meat and the liquor from Meat of previous day, 12 oz. Potatoes and other Vegetables, and 1 oz. Dumpling. 6 oz. Bread. ½ pint Beer.
TEA or SUPPER ...	... ...	6 oz. Bread. 2 oz. Cheese or ½ oz. Butter. ½ pint Beer or 1 pint Tea.

FEMALES.

BREAKFAST	... ...	5 oz. Bread and ½ oz. Butter. 1 pint Tea.
DINNER	TUESDAY	13 oz. Pie (containing 4 oz. Meat). 8 oz. Vegetables. ½-pint Beer.
	MONDAY, THURSDAY, FRIDAY, SUNDAY	4 oz. Cooked Meat. 8 oz. Vegetables. 4 oz. Bread. ½-pint Beer.
	WEDNESDAY	1 pint Soup, made with 4 oz. Meat and the liquor from Meat of previous day, Peas, Rice, Scotch Barley, Herbs, etc. 5 oz. Bread. *or* 8 oz. Fish. 8 oz. Vegetables. 4 oz. Bread. *or* 12 oz. Currant Dumpling. ½ pint Beer (with either Dinner).
	SATURDAY	1 pint Irish stew, made with 3 oz. Meat and the liquor from Meat of previous day, 12 oz. Potatoes and other Vegetables, and 1 oz. Dumpling. 5 oz. Bread. ½ pint Beer.
TEA	... ...	5 oz. Bread. ½ oz. Butter. 1 pint Tea.

SURREY COUNTY LUNATIC ASYLUM, WANDSWORTH.

(*From the Report for* 1874.)

PRESENT DIETARY.

DAYS.	BREAKFAST.	DINNER.	SUPPER.
Sunday	Cocoa, 1 pint, with Bread and Butter.	Australian Corned Beef, 6 oz. males, and 5 oz. females, with Vegetables, Bread, and ½ pint of Beer.	Tea, 1 pint, with Bread and Butter.
Monday	Ditto	Boiled Beef, 7 oz., with Vegetables, Bread, and ½ pint of Beer.	Ditto
Tuesday	Ditto	Baked Stew, with 4 oz. of Meat for males, and 3½ oz. for females, Vegetables, Bread, and ½ pint of Beer.	Ditto
Wednesday	Ditto	Boiled Fresh Fish, 12 oz. (before cooking), Vegetables, Bread, and ½ pint of Beer.	Ditto
Thursday ...	Ditto	Meat Pie, containing 5 oz. Meat for males, and 4 oz. for females, Vegetables, Bread, and ½ pint of Beer.	Ditto
Friday	Ditto	Baked Stew, etc., as on Tuesday.	Ditto
Saturday.....	Ditto	Boiled Mutton, 8 oz., Vegetables, Bread, and ½ pint of Beer.	Ditto

All patients who are employed are allowed for Luncheon, Bread and Cheese, with half a pint of Beer, and in the afternoon half a pint of Beer. The Sick throughout the establishment are dieted at the discretion of the Medical Superintendent.

The minced dinners for Epileptics, Paralytics, etc., to consist of—For males: Australian Mutton, 4 oz.; Bread, 4 oz.; Vegetables, 8 oz. For females: Australian Mutton, 4 oz.; Bread, 2 oz.; Vegetables, 8 oz.

CITY OF LONDON - -

(*From the Report* -

DIETARY

DAYS OF THE WEEK.	BREAKFAST.						DINNER.						
	MALES.			FEMALES.			MALES.						
	Cocoa.	Bread.	Butter.	Cocoa.	Bread.	Butter.	Uncooked Meat without bone.	Potatoes.	Bread.	Beer.	Soup.	Pie.	Suet Pudding with Treacle.
	pints.	oz.	oz.	pints.	oz.	oz.	oz.	oz.	oz.	pints.	pints.	oz.	oz.
Sunday	1	8	½	1	6	½	7	12	2	½	...	...	...
Monday	1	8	½	1	6	½	7	12	2	½	...	...	...
Tuesday	1	8	½	1	6	½	3	...	6	½	1½	...	...
Wednesday	1	8	½	1	6	½	7	12	2	½	...	...	...
Thursday	1	8	½	1	6	½	3	8	...	½	...	16	...
Friday	1	8	½	1	6	½	7	12	2	½	...	...	...
Saturday	1	8	½	1	6	½	...	...	...	½	...	...	16
	7	56	3½	7	42	3½	34	56	14	3½	1½	16	16

The Extra Diet as per Summaries of Sick List.

The Diet of Attendants and Servants.—Daily—Male Attendants: Meat uncooked, 1 lb.; Vegetables, 1 lb.; Bread, 1 lb.; Beer, 2 pints. Female Attendants: Meat uncooked, ¾ lb.; Vegetables, 1 lb.; Bread, 1 lb.; Beer, 2 pints. Weekly—Butter, ½ lb.; Cheese, 1 lb.; Sugar, ¼ lb.; Tea, 3 oz. each.

The Night Attendants have 1 lb. Coffee each per week in addition to the above.

Cocoa for Ten Patients: 5 oz. Cocoa; 7 oz. Sugar; 2 pints Milk.

Tea for Ten Patients: 1½ oz. Tea; 6½ oz. Sugar; 1 pint Milk.

METROPOLITAN DISTRICT

LEAVESDEN - -

(*From the Report*

DIETARY

DAYS OF THE WEEK.	BREAKFAST.						DINNER.						
	MALES.			FEMALES.			MALES.						
	Bread.	Butter.	Tea or Cocoa.	Bread.	Butter. *	Tea or Cocoa.	Pie, containing 4 oz. of Meat.	Meat cooked, free from bone.	Fish cooked, free from heads, with 2 oz. of Melted Butter.	Irish Stew. ‡	Vegetables or Rice.	Bread.	Beer.
	oz.	oz.	pints.	oz.	oz.	pints.	oz.	oz.	oz.	pints.	oz.	oz.	pints.
Monday	6	½	1	5	½	1	13	...	...	...	9	...	½
Tuesday	6	½	1	5	½	1	...	5	...	...	10	4	½
Wednesday	6	½	1	5	½	1	...	...	10†	1	10	4	½
Thursday	6	½	1	5	½	1	...	5	...	...	10	4	½
Friday	6	½	1	5	½	1	...	5	...	...	10	4	½
Saturday	6	½	1	5	½	1	...	...	...	1	...	4	½
Sunday	6	½	1	5	½	1	...	5	...	...	10	4	½

Male and female patients laboriously employed are allowed Bread and Cheese and half-pint of Beer at 11 a.m., and half-pint Beer at 4 p.m. The diet for children of both sexes is the same as the diet for females.

* In lieu of the ½ oz. of Butter daily, the female patients may be given an extra ounce of Cooked Meat on each of the four Meat days.

† In the table for Caterham the quantities are—9 oz. males, 8 oz. females.

‡ The Irish Stew is to be made with 3 oz. Meat and the liquor from the Meat of the previous day, 12 oz. Potatoes and other Vegetables, and 4 oz. Dumpling for the males, and 3 oz. for the females.

LUNATIC ASYLUM, STONE.

- - - *for* 1874.)

- *TABLE.*

DINNER.							SUPPER.						
FEMALES.							MALES.			FEMALES.			
Uncooked Meat without bone.	Potatoes.	Bread.	Beer.	Soup.	Pie.	Suet Pudding with Treacle.	Bread.	Butter.	Tea.	Bread.	Butter.	Tea.	
oz.	oz.	oz.	pints.	pints.	oz.	oz.	oz.	oz.	pints.	oz.	oz.	pints.	
7	12	2	½	...	...	...	6	½	1	6	½	1	Sunday, Boiled Mutton.
7	12	2	½	...	...	...	6	½	1	6	½	1	Monday, Boiled Beef.
3	...	4	½	1½	...	...	6	½	1	6	½	1	Tuesday, Soup.
7	12	2	½	...	...	...	6	½	1	6	½	1	Wednesday, Roast Beef.
3	8	...	½	...	14	...	6	½	1	6	½	1	Thursday, Pie.
7	12	2	½	...	...	...	6	½	1	6	½	1	Friday, Boiled Beef.
...	...	...	½	...	...	14	6	½	1	6	½	1	Saturday, Suet Pudding.
34	56	12	3½	1½	14	14	42	3½	7	42	3½	7	

Soup: The liquor of the Cooked Meat, Bones, etc., with Meat, Oatmeal, Rice, Potatoes, Turnips, Onions, and Salt and Pepper added.

Suet Dumplings, with Treacle Sauce, to be varied by Currant Dumplings and Fruit Pies in the season.

Tobacco and Snuff are given as indulgences to the Patients who are employed in Field-work, etc., and to other Patients, by order of the Medical Superintendent.

Seed Cake is given to the Patients on Sundays in lieu of Bread and Butter.

At 11 a.m., 2 oz. Bread, 1 oz. Cheese, ½ pint Beer, is given to all Patients who are usefully employed, and at 7 p.m. also to those who have been engaged in the Field, Workshops, or Laundry.

ASYLUMS FOR IMBECILES,

AND CATERHAM.

- - *for* 1874.)

TABLE.

DINNER.									TEA.							
FEMALES.									MALES.					FEMALES.		
Pie, containing 4 oz. of Meat.	Meat cooked, free from bone. *	Fish cooked, free from heads, with 2 oz. of Melted Butter.	Soup. ‡	Currant Dumpling.	Irish Stew.	Vegetables or Rice.	Bread.	Beer.	Bread.	Butter.	Cheese.	Beer.	Tea.	Bread.	Butter.	Tea.
oz.	oz.	oz.	pints.	oz.	pints.	oz.	oz.	oz.	oz.	oz.	oz.	pints.	pints.	oz.	oz.	pints.
13	...	...	...	...	...	8	...	½	6	½	...	...	1	5	½	1
...	4	...	...	...	...	9	4	½	6	½	...	...	1	5	½	1
...	...	9†	...	...	...	9	4	½	6	½	...	...	1	5	½	1
...	4	...	...	...	...	9	4	½	6	½	...	...	1	5	½	1
...	4	...	...	...	...	9	4	½	6	½	...	...	1	5	½	1
...	...	...	...	...	1	...	4	½	6	½	...	...	1	5	½	1
...	4	...	...	...	...	9	4	½	6	½	...	...	1	5	½	1

* In lieu of the ½ oz. of Butter daily, the female patients may be given an extra ounce of Cooked Meat on each of the four Meat days.

† In the table for Caterham the quantities are—9 oz. males, 8 oz. females.

‡ The Soup is to be made with 4 oz. Meat and the liquor from the Meat of the previous day, Peas, Rice, Scotch Barley, Herbs, etc.

ST. LUKE'S - -

(*From the*

MALE - -

DAYS OF THE WEEK.	BREAKFAST.						
	Cocoa.	Milk.	Sugar.	Bread.	Butter.	Cooked Meat with Bone.	Meat Pies with Potatoes.
	oz.	pints.	oz.	oz.	oz.	oz.	oz.
Sunday	½	⅛	½	8	½	6	...
Monday	½	⅛	½	8	½	...	12
Tuesday	½	⅛	½	8	½	8	...
Wednesday	½	⅛	½	8	½	...	...
Thursday	½	⅛	½	8	½	8	...
Friday	½	⅛	½	8	½	8	...
Saturday	½	⅛	½	8	½	8	...
Week's Allowance	3½	1⅜	3½	56	3½	38	12

FEMALE - -

DAYS OF THE WEEK.	BREAKFAST.						
	Cocoa.	Milk.	Sugar.	Bread.	Butter.	Cooked Meat with Bone.	Meat Pies with Potatoes.
	oz.	pints.	oz.	oz.	oz.	oz.	oz.
Sunday	½	⅛	½	6	½	4	...
Monday	½	⅛	½	6	½	...	10
Tuesday	½	⅛	½	6	½	6	...
Wednesday	½	⅛	½	6	½	...	...
Thursday	½	⅛	½	6	½	6	...
Friday	½	⅛	½	6	½	6	...
Saturday	½	⅛	½	6	½	6	...
Week's Allowance	3½	1⅜	3½	42	3½	28	10

One pint of Beer, 8 oz. of Bread, and 2 oz. of Cheese, may be had for Supper in the place of the ordinary Tea, by those male patients for whom the Medical Officer shall think it desirable.

Patients employed in work for the Hospital to be allowed 4 oz. Bread, 1 oz. of Cheese, and ½ pint of Beer for Lunch.

The Dinners may be varied by the occasional substitution of Pork, Bacon, Salt Beef, or Veal,

- - HOSPITAL.

Report for 1874.)

- - *DIETARY.*

DINNER.						TEA.				
Meat Puddings.	Potatoes.	Greens.	Bread.	Beer.	† Pudding.	Tea.	Sugar.	Milk.	Bread.	Butter.
oz.	oz.	oz.	oz.	pints.	oz.	oz.	oz.	pints.	oz.	oz.
...	12	...	6	1	6	⅛	½	⅛	8	½
...	...	...	3	1	...	⅛	½	⅛	8	½
...	...	*	6	1	...	⅛	½	⅛	8	½
12	8	...	3	1	...	⅛	½	⅛	8	½
...	...	*	6	1	...	⅛	½	⅛	8	½
...	12	...	6	1	...	⅛	½	⅛	8	½
...	...	*	6	1	..	⅛	½	⅛	8	½
12	32	...	36	7	6	1	3½	⅞	56	3½

- - *DIETARY.*

DINNER.						TEA.				
Meat Puddings.	Potatoes.	Greens.	Bread.	Beer.	† Pudding.	Tea.	Sugar.	Milk.	Bread.	Butter.
oz.	oz.	oz.	oz.	pints.	oz.	oz.	oz.	pints.	oz.	oz.
...	8	...	6	¾	6	⅛	½	⅛	8	½
...	...	...	3	¾	..	⅛	½	⅛	8	½
...	...	*	6	¾	...	⅛	½	⅛	8	½
10	6	...	3	¾	...	⅛	½	⅛	8	½
...	...	*	6	¾	...	⅛	½	⅛	8	½
...	8	...	6	¾	...	⅛	½	⅛	8	½
...	...	*	6	¾	...	⅛	½	⅛	8	½
10	22	...	36	5¼	6	1	3½	⅞	56	3½

when in season; and also the occasional substitution of Fish, and Fruit Pies, when either are plentiful and good.

Lettuce during the Summer Months may be substituted occasionally for other Vegetables.

The Sick to be dieted at the discretion of the Medical Officers.

The above to be considered maximum allowances; and all quantities unconsumed to be returned to the Kitchen

† *i.e.*, Farinaceous or Fruit.

BETHLEM ROYAL HOSPITAL.

(*From the Report for* 1874.)

Breakfast.

Every Day. Males .. Tea, with 7 oz. of Bread and Butter.
Females ,, 6 ditto

Dinner.

Sunday ...	Males	6 oz. Boiled Beef free from bone	4 oz.	Bread,	¾lb.	Vegetables,	1 pt.	Beer.
	Females..	5 ,,	,,	4	,,	½	,,	½	,,
Monday ...	Males ...	6 ,,	Roast Mutton,	4	,,	¾	,,	1	,,
	Females..	5 ,,	,,	4	,,	½	,,	½	,,
Tuesday ...	Males ...	6 ,,	Boiled Mutton,	4	,,	¾	,,	1	,,
	Females..	5 ,,	,,	4	,,	½	,,	½	,,
Wednesday	Males ...	6 ,,	Roast Beef,	4	,,	¾	,,	1	,,
	Females..	5 ,,	,,	4	,,	½	,,	½	,,
Thursday	Same as Monday.								
Friday	Same as Tuesday.								
Saturday ...	Males ...	16 oz.	Meat Pie,	4 oz.	Bread,	1 oz.	Cheese,	1 pt.	Beer.
	Females.	14 ,,	,,	4	,,	1	,,	½	,,

Supper.

Sunday, Monday, Tuesday, Thursday, and Friday } Males..... Same as Breakfast.
Wednesday and Saturday... Males..... 7 oz. Bread, 2 oz. Cheese, 1 pint Beer.
Every Day.. .... Females... Same as Breakfast.

Patients in employment in tbe Grounds, Workshops, or Laundry, to be allowed 4 oz. of Bread, 1 oz. of Cheese or ½ oz. of Butter, and ¼ a pint of Beer for Luncheon, and ¼ a pint of Beer in the Afternoon.

Every Patient to be allowed 1¾ oz. Tea, 8 oz. of Sugar, 8 oz. of Butter, and 1½ pint Milk weekly.

On Christmas Day, the Dinner to be Roast Beef and Plum Pudding.

On New Year's Day, a Mince Pie to be added to the usual fare.

On Good Friday, a Bun.

On Easter and Whit Monday, 6 oz. Roast Veal to be allowed instead of the usual Meat for the day.

The Steward has liberty to vary the diet occasionally by Pork and Bacon, when Peas and Beans are in season ; and by Fish, Fruit Pies, etc., when Fish and Fruit are plentiful and good.

The Sick to be dieted at the discretion of the Resident Physician.

The Attendants to have at all times the means of obtaining Gruel for such patients as may require it.

The above to be considered maximum allowances, and all quantities unconsumed are to be taken in diminution of the next supply from the Stores of the Hospital.

METROPOLITAN LICENSED HOUSES.

1874.

CAMBERWELL HOUSE PAUPER DIETARY SCALE.

(*Communicated.*)

BREAKFAST.

Every Day.... Males.—1 pint of Tea, with Bread* and Butter,† *ad libitum*.
Females.—Same.

DINNER.

Sunday.....Males.—Roast or Boiled Beef, *ad libitum*, averaging 10 oz. of Uncooked Meat, free from bone, to each person—always in the joint, and carved in the wards—with Potatoes and Bread, *ad libitum*, and ½ pint of Beer.
Females.—Same, *ad libitum*, averaging 8 oz. of Uncooked Meat, free from bone—always in the joint, and carved in the wards—with Potatoes and Bread, *ad libitum*, and ½ pint of Beer.

Monday.....Males.—Hash, or Meat Pie,‡ averaging 6 oz. of Meat without bone, with Vegetables and Bread, *ad libitum*, and ½ pint of Beer.
Females.—Same.

Tuesday.....Males.—Roast or Boiled Mutton, averaging 10 oz. of Uncooked Meat without bone, with Vegetables and Bread, *ad libitum*, and ½ pint of Beer.
Females.—Same, but averaging 8 oz. of Uncooked Meat, free from bone, Vegetables, Bread, and Beer.

Wednesday....Males.—Irish Stew, averaging 3 oz. of Cooked Meat, with Vegetables, etc.; and Plum Pudding,§ *ad libitum*, but averaging ¾ lb. to each person, or baked Bread Puddings with Currants,§ and ½ pint of Beer.
Females.—Same. Plum Pudding or baked Bread Pudding, *ad libitum*, but averaging ½ lb. to each person. Beer, ½ pint.

Thursday.....Males.—Same as Sunday—occasionally Veal or Pork—and ½ pint of Beer.
Females.—Same.

Friday.....Males.—Same as Tuesday, but occasionally Fish, *ad libitum*.
Females.—Same.

Saturday.....Males.—Boiled Beef, or same as Sunday, averaging 10 oz. to each person, Vegetables and Bread, and ½ pint of Beer.
Females.—Same, *ad libitum*, but averaging 8 oz. of Uncooked Meat, free from bone, with Vegetables, Bread, and Beer.

TEA.

Every Day.... Males.—1 pint of Tea, with an unlimited quantity of Bread and Butter.
Females.—Same.

All workers and assistants in wards are allowed Bread and Cheese and ½ pint of Porter for both Luncheon and Supper.

* The quantity of Bread issued to the wards is equal to 20 oz. to each person, male and female, per diem.

† The Butter amounts to 8 oz. per week to each patient of both sexes.

‡ Meat Pie.—6 oz. of Meat, 6 oz. of Flour, with Dripping, and ½ oz. of Onions; occasionally 8 oz. of Potatoes introduced.

§ The Pudding is made with 12 oz. of Flour, 4 oz. of Suet, 3 oz. of Currants and Raisins, and Milk.

BETHNAL HOUSE.

(*Communicated.*)

ORDINARY DIET FOR PAUPER PATIENTS.

BREAKFAST AND TEA.

	Males.	Females.
Bread	6 oz.	5 oz.
Butter	½ oz.	½ oz.
Tea	1 pint.	¾ pint.

DINNER.

		Cooked and free from bone. M.	F.
Sunday	Roast Mutton	6 oz.	5 oz.
Monday	Boiled Beef	6 oz.	5 oz.
Tuesday	Meat Pie	4 oz.	4 oz.
Wednesday	Boiled Mutton	6 oz.	5 oz.
Thursday	Boiled Beef	6 oz.	5 oz.
Friday	Currant Pudding	16 oz.	12 oz.
Saturday	Meat Pie	4 oz.	4 oz.
Daily (except Friday)	Vegetables	12 oz.	10 oz.
,,	Table Beer	1 pint.	½ pint.

SUPPER.

	Males.	Females.
Table Beer	1 pint.	½ pint.
Cheese	2 oz.	1½ oz.
Bread	4 oz.	4 oz.

Sick or infirm, as well as workers, have Luncheon, and anything the Medical Superintendent chooses to order.

HOXTON HOUSE.

(*Communicated.*)

DIET LIST FOR PAUPER PATIENTS.

BREAKFAST... Bread, *ad libitum* ; Butter, ⅓ oz. ; Coffee, 1 pint.

DINNER ..... Fresh Meat, cooked and free from bone—men, 5 oz. ; women, 4 oz. Fresh Vegetables, 12 oz. Bread, *ad lib.* Beer—men, 1 pint ; women, ⅔ pint. Salt Beef, Ham, or Bacon are given occasionally in place of Fresh Meat, and much enjoyed by the inmates. Fish Dinners are sometimes given ; also Bread and other Puddings.

SUPPER ..... Bread, *ad libitum ;* Butter, ⅓ oz. ; Tea, 1 pint.

Workers are allowed Bread and Cheese and extra Beer for Luncheon and Supper in addition.

The Extra and Sick Diet List comprises Fowl, Minced Meat, Fish, Eggs, Bacon, Beef Tea, Mild Arrowroot, Rice Pudding, Ale, Stout, Wine, Brandy, Gin, Whisky.

The Private Patients have a more liberal and varied diet.

PECKHAM HOUSE, PECKHAM.

(*Communicated.*)

DIETARY SCALE FOR PAUPER PATIENTS.

BREAKFAST.—Cocoa daily, with Bread and Butter *ad libitum.*

TEA.—Tea daily, with Bread and Butter *ad libitum.*

DINNERS.

Monday ..... Pea Soup, containing 4 oz. of Cooked Meat free from bone per head, with Rice and Vegetables; Bread Pudding with Currants; Bread; Beer.

Tuesday..... Meat Pie, containing 5 oz. of Cooked Meat free from bone per head; Potatoes; Bread; Beer.

Wednesday.. Boiled Meat, 5 oz. cooked and free from bone per head; Potatoes and other Vegetables; Bread; Beer.

Thursday .... Irish Stew, containing 4 oz. of Cooked Meat free from bone per head, with Potatoes, Carrots, Turnips and Onions, also small Dumplings; Bread Pudding with Currants; Bread; Beer.

Friday ..... Same as Tuesday.

Saturday..... Same as Monday.

Sunday ..... Bacon, 6 oz. free from bone when cooked; Cabbage or other Vegetables, and Potatoes; Bread; Beer.

In addition to the half-pint of Beer daily at Dinner-time, the helpers in the wards, and those otherwise occupied, have half a pint of Porter, with Bread and Cheese, for both Luncheon and Supper.

GROVE HALL, BOW.

(*Communicated.*)

SCALE FOR MILITARY PATIENTS.

BREAKFAST... Coffee (Milk and Sugar), 1 pint; Bread and Butter, 8 oz., with extra for those who wish it—the average in some wards being 9⅓ oz. per man.

TEA ..... Same as Breakfast (Tea instead of Coffee).

DINNERS..... Porter, ½ pint every day.

I. Joint days (2 days in week). 7 oz. Meat; 24 oz. Vegetables, 16 of which are Potatoes.

II. Meat and Potato Pie and Pudding days (3 days in week).—Minimum = 21 oz., containing 4 oz. Meat; 22 and 24 oz. to more active patients.

III. Irish Stew days (2 days in week).—4 oz. Suet Pudding; 3 oz. Bread; Irish Stew, *ad libitum.* The Stew is thick—consists of Meat, Potatoes, other Vegetables, Bread, Spices, etc.

LUNCH..... Bread (3 oz.) and Cheese, and half a pint of Porter.

SUPPER ..... Ditto.

Lunch and Supper to working men; Supper to ward helpers.

The following Diet Tables were reported by the Commissioners in Lunacy in 1864:—

MIDDLESEX COUNTY - - LUNATIC ASYLUM, HANWELL.

(From the Commissioners' - - Report for 1863.)

ORDINARY - - DIET.

	BREAKFAST.				DINNER.							DINNER.							SUPPER.						
	MALES.		FEMALES.		MALES.							FEMALES.							MALES.			FEMALES.			
	Bread.	Cocoa.	Bread.	Cocoa.	Beer.	Bread.	Cooked Meat.	Dumplings.	Pie.	Stew.	Vegetables.	Beer.	Bread.	Cooked Meat.	Dumplings.	Pie.	Stew.	Vegetables.	Beer.	Bread.	Cheese.	Tea.	Bread.	Butter.	
	oz.	pints.	oz.	pints.	pints.	oz.	oz.	oz.	oz.	oz.	oz.	pints.	oz.	oz.	oz.	oz.	oz.	oz.	pints.	oz.	oz.	pints.	oz.	oz.	
Sunday	6	1	5	1	½	...	5	4	...	...	12	½	...	5	4	...	...	12	½	6	2	1	5	½	Meat dinner.
Monday	6	1	5	1	½	...	5	4	...	...	12	½	...	5	4	...	...	12	½	6	2	1	5	½	Meat dinner.
Tuesday	6	1	5	1	½	...	5	4	...	...	12	½	...	5	4	...	...	12	½	6	2	1	5	½	Meat dinner.
Wednesday	6	1	5	1	½	...	1½	...	10	...	4	½	...	1½	...	10	...	4	½	6	2	1	5	½	Pie dinner.
Thursday	6	1	5	1	½	...	5	4	...	...	12	½	...	5	4	...	...	12	½	6	2	1	5	½	Meat dinner.
Friday	6	1	5	1	½	...	5	4	...	...	12	½	...	5	4	...	...	12	½	6	2	1	5	½	Meat dinner.
Saturday	6	1	5	1	½	6	1½	...	...	14	...	½	6	1½	...	...	14	...	½	6	2	1	5	½	Stew dinner.
Total	42	7	35	7	3½	6	28	20	10	14	64	3½	6	28	20	10	14	64	3½	42	14	7	35	3½	

N.B.—Cocoa in the following proportions, viz.:—For 1 pint—½ oz Cocoa, 1 oz. Treacle, ½ pint Milk. Stew for 1150 patients: The liquor of the Meat cooked the previous day, 168 lbs. Meat, 840 lbs. Potatoes, 180 lbs. Onions, with Salt and Pepper. Currant Dumplings are occasionally given in lieu of Stew, 12 oz. to the male, and 11 oz. to the female patients. Fruit and Rhubarb Pies are given in lieu of Meat Pies in the season; Mustard given whenever Suet Pies or Roast Pork is for dinner. ½ pint Tea and 2 oz. Bread for each male patient at 5.30 every day. ½ pint Beer at 11 a.m. and 4 p.m. daily for male and female patients employed during the day. Tobacco and Snuff given as indulgences to the patients who are employed.

MIDDLESEX COUNTY LUNATIC ASYLUM, COLNEY HATCH.

(From the Commissioners' - - Report for 1863.)

ORDINARY DIET TABLE.

	BREAKFAST.				DINNER.						DINNER.														SUPPER.						
	MALES.		FEMALES.		MALES.						FEMALES.														MALES.			FEMALES.			
											Dining in Hall.						Dining in Wards.														
	Bread.	Cocoa.	Bread.	Cocoa.	Bread.	Meat cooked.	Vegetables.	Soup.	Pie.	Beer.	Bread.	Meat cooked.	Vegetables.	Soup.	Pie.	Beer.	Bread.	Meat cooked.	Vegetables.	Soup.	Pie.	Beer.	Bread.	Cheese.	Beer.	Bread.	Butter.	Tea.			
	oz.	pints.	oz.	pints.	oz.	oz.	oz.	pints.	oz.	pints.	oz.	oz.	oz.	pints.	oz.	pints.	oz.	oz.	oz.	pints.	pints.	oz.	oz.	oz.	pints.	oz.	oz.	pints			
Sunday	6	1	5	1	4	5	12	...	...	½	4	5	12	...	...	½	4	5	12	...	...	½	6	2	½	5	½	1			
Monday	6	1	5	1	6	...	...	1*	...	½	5	...	...	1	...	½	5	...	...	1	...	½	6	2	½	5	½	1			
Tuesday	6	1	5	1	4	5	12	...	...	½	4	5	12	...	...	½	4	5	12	...	...	½	6	2	½	5	½	1			
Wednesday	6	1	5	1	4	5	12	...	...	½	4	5	12	...	...	½	4	5	12	...	...	½	6	2	½	5	½	1			
Thursday	6	1	5	1	4	5	12	...	...	½	4	5	12	...	...	½	5	2	...	...	1	½	6	2	½	5	½	1			
Friday	6	1	5	1	4	5	12	...	...	½	4	5	12	...	...	½	4	5	12	...	...	½	6	2	½	5	½	1			
Saturday	6	1	5	1	...	2	4	...	10	½	...	2	4	...	10	½	...	2	4	...	10	½	6	2	½	5	½	1			

* Wards 10, 14, and B. 3 have Batter Pudding, made with 2 oz. Meat, 8 oz. Flour, and 1 oz. Suet.

Patients employed upon the Farm and Garden, in the Workshops, or Domestic Offices, receive the following extra diet:—Male patients: Bread and Cheese and ½ pint Beer at 11 a.m.; ½ pint Beer at 4 p.m.; Bread and Butter and 1 pint Tea at 5 p.m. Laundry-women and patients employed in the Kitchen: Bread and Cheese and ½ pint Beer at 11 a.m.

SURREY COUNTY LUNATIC ASYLUM, WANDSWORTH.

(*From the Commissioners' Report for* 1863.)

ORDINARY DIET TABLE.

DAYS.	BREAKFAST.	DINNER.	SUPPER.
Monday	Cocoa, 1 pint, with Bread and Butter.	Boiled Beef, 7 oz., with Vegetables, Bread, and ½ pint of Beer.	Tea, 1 pint, with Bread and Butter.
Tuesday	Ditto	Baked Stew, with 4 oz. of Meat for males, and 3½ oz. for females, Vegetables, Bread, and ½ pint of Beer.	Ditto
Wednesday	Ditto	Meat Pie, containing 5 oz. Meat for males, and 4 oz. for females, Vegetables and Beer as before.	Ditto
Thursday ...	Ditto	Baked Stew, etc., as on Tuesday.	Ditto
Friday	Ditto	Boiled Beef, etc., as on Monday.	Ditto
Saturday.....	Ditto	Boiled Mutton, 8 oz., Vegetables, Bread, and Beer as before.	Ditto
Sunday	Ditto	Roast Beef, 8 oz. males, and 7 oz. females, with Vegetables, Bread, and Beer as before.	Ditto

The quantity of Meat weighed out from the Stores amounts weekly for male patients to 2 lbs. 11 oz., and for female patients to 2 lbs. 8 oz., which is exclusive of bone.

The male patients who work in the Garden and Farm, as well as those employed as Bricklayers, Carpenters, etc., are allowed for Luncheon Bread and Cheese, with half a pint of Beer, and in the afternoon half a pint of Beer each; and the females employed in the Kitchen and Laundry, Bread and Cheese, with half a pint of Beer, and in the afternoon half a pint of Beer each.

The following were reported in 1854 :—

SURREY COUNTY LUNATIC ASYLUM, WANDSWORTH.

(*From the Eighth Report of the Commissioners*, 1854.)

DIETARY.

DAYS.	BREAKFAST.	DINNER.	SUPPER.
Monday	1 pint of Milk Porridge, with 6 oz. Bread for males, and 4 oz. for females.	Soup thickened with Barley, Peas and Vegetables, and 6 oz. of Bread.	1 pint of Milk Porridge, with 6 oz. of Bread for males, and 4 oz. for females.
Tuesday	Ditto	Boiled Beef, 6 oz. free from bone, with 4 oz. of bread, ¾ pint of beer for males, and ½ pint for females, with Vegetables.	Ditto
Wednesday	Ditto	Baked or boiled Suet Pudding, 10 oz. for males, and 12 oz. for females, with ½ pint of beer for males, and ½ pint for females.	Ditto
Thursday ...	Ditto	Meat Pie, with 5 oz. of Meat for males, 4 oz. for females. Vegetables and Beer as before.	Ditto
Friday.....	Ditto	Baked Rice Puddings, or boiled Rice in Milk, with Beer as before, or Soup, as on Monday.	Ditto
Saturday... ..	Ditto	Boiled Beef, etc., as on Tuesday.	Ditto
Sunday	Ditto	Boiled or Roast Mutton or Beef, as on Tuesday.	Ditto

The male patients who work in the Garden and Farm, as well as those employed as Bricklayers, Carpenters, Painters, Plumbers, and Glaziers, and in the Engine-house, are allowed for Luncheon Bread and Cheese, with three-quarters of a pint of Beer, and in the afternoon half a pint of Beer; and the females employed in the Kitchen and Laundry, Bread and Cheese, with half a pint of Beer each; and the whole of the female patients in employment, whether in the Kitchen, Laundry, or Wards, receive weekly one ounce and a half of Tea, six ounces of Sugar, and six ounces of Butter.

MIDDLESEX COUNTY LUNATIC

(From the Eighth Report
ORDINARY

DAYS OF THE WEEK.	BREAKFAST.				DINNER.							
	MALES.		FEMALES.		MALES.							
	Bread.	Cocoa.	Bread.	Cocoa.	Beer.	Bread.	Cooked Meat.	Dumplings.	Pie.	Stew.	Vegetables.
	oz.	pints.	oz.	pints.	pints.	oz.	oz.	oz.	oz.	oz.	oz.
Sunday.....	6	1	5	1	½	...	5	4	...	...	12
Monday	6	1	5	1	½	...	5	4	...	...	12
Tuesday	6	1	5	1	½	...	5	4	...	...	12
Wednesday	6	1	5	1	½	...	5	4	...	...	12
Thursday.....	6	1	5	1	½	6	1½	...	...	14	...
Friday	6	1	5	1	½	...	5	4	...	...	12
Saturday	6	1	5	1	½	...	1½	...	10	...	4
Total.....	42	7	35	7	3½	6	28	20	10	14	64

N.B.—The Meat for each patient, weekly, weighs 39 oz. before cooking; the Beef free from bone. Cocoa in the following proportions for one pint, viz.:—4 oz. Cocoa, 1 oz. Treacle, ½ pint Milk. Half-pint Tea and 2 oz. Bread for each male patient at ½ past 5 p.m. Stew for 900 patients: The liquor of the meat cooked the previous day, 112 lbs. Meat, 560 lbs. Potatoes, 120 lbs. Onions, Salt, and Pepper. Fruit Pies are given in lieu of Meat Pies in the season. Currant Dumplings are occasionally given in lieu of Stew, 12 oz. to the males, and 11 oz. to the females.

MIDDLESEX COUNTY LUNATIC

(From the Eighth Report
ORDINARY DIETARY

DAYS OF THE WEEK.	BREAKFAST.				DINNER.								
	MALES.		FEMALES.		MALES.								
	Bread.	Cocoa.	Bread.	Cocoa.	Beer.	Bread.	Uncooked Meat.	Dumplings.	Pie.	Soup.	Butter.	Vegetables.
	oz.	pints.	oz.	pints.	pints.	oz.	oz.	oz.	oz.	pints.	oz.	oz.
Sunday	6	1	5	1	½	...	7	4	...	...	...	12
Monday ...	6	1	5	1	½	...	7	4	...	...	...	12
Tuesday ...	6	1	5	1	½	...	2	...	...	...	13	...
Wednesday	6	1	5	1	½	...	7	4	...	...	...	12
Thursday ...	6	1	5	1	½	...	2	...	...	...	13	..
Friday	6	1	5		½	...	7	4	...	...	...	12
Saturday ...	6	1	5	1	½	...	2	...	10	...	...	4
Total.....	42	7	35	7	3½	...	34	16	10	...	26	52

N.B.—Cocoa in the following proportions for one pint, viz. :—¼ oz. Cocoa, 1 oz. Treacle, ½ pint of Milk. Soup for 900 patients: The liquor of the Meat cooked the previous day, 112 lbs. Leg and Shins of Beef, 60 lbs. Peas, 50 lbs. Rice, 20 lbs. Scotch Barley, 40 lbs. Onions, Salt, and Pepper, with Herbs. Stew for 900 patients: The liquor of the Meat cooked the previous day, 112 lbs. Meat, 560 lbs. Potatoes, 120 lbs. Onions, Salt, and Pepper. Fruit Pies to be given in lieu of

- - - ASYLUM, HANWELL.

of the Commissioners, 1854.)
DIET.

	DINNER.								SUPPER.					
	FEMALES.								MALES.			FEMALES.		
	Beer.	Bread.	Cooked Meat.	Dumplings.	Pie.	Stew.	Vegetables		Beer.	Bread.	Cheese.	Bread.	Butter.	Tea.
	pints.	oz.	oz.	oz.	oz.	oz.	oz.		pints.	oz.	oz.	oz.	oz.	pints.
	½	...	5	4	...	...	12		½	6	2	5	½	1
	½	...	5	4	...	...	12		½	6	2	5	½	1
	½	...	5	4	...	...	12		½	6	2	5	½	1
	½	...	5	4	...	...	12		½	6	2	5	½	1
	½	5	2½	...	...	14	...		½	6	2	5	½	1
	½	...	5	4	...	...	12		½	6	2	5	½	1
	½	...	2½	...	10	...	4		½	6	2	5	½	1
	3½	5	28	20	10	14	64		3½	42	14	35	3½	7

Extra.—Outdoor workers and Artisans, ½ pint beer at 11 o'clock a.m., and at 4 p.m. Laundry women, ½ pint of Beer, with Bread and Cheese, at 11 a.m. Kitchen and Bakehouse women, 1 pint Beer extra daily. In Female Workroom, ½ pint Beer each, at 11 o'clock a.m. Tobacco and Snuff given as indulgences to the workers, etc.

- - ASYLUM, COLNEY HATCH.

of the Commissioners, 1854.)
- - FOR THE PATIENTS.

	DINNER.									SUPPER.					
	FEMALES.									MALES.			FEMALES.		
	Beer.	Bread.	Uncooked Meat.	Dumplings.	Pie.	Soup.	Stew.	Vegetables		Beer.	Bread.	Cheese.	Bread.	Butter.	Tea.
	pints.	oz.	oz.	oz.	oz.	pints.	oz.	oz.		pints.	oz.	oz.	oz.	oz.	pints.
	½	...	7	4	...	...	...	12		½	6	2	5	½	1
	½	5	...	...	...	1	...	...		½	6	2	5	½	1
	½	...	7	4	...	...	...	12		½	6	2	5	½	1
	½	...	7	4	...	...	...	12		½	6	2	5	½	1
	½	5	2	...	...	...	14	...		½	6	2	5	½	1
	½	...	7	4	...	...	...	12		½	6	2	5	½	1
	½	...	2	...	10	...	...	4		½	6	2	5	½	1
	3½	10	32	16	10	1	14	52		3½	42	14	35	3½	7

Meat Pies in the season. Currant Dumplings to be given occasionally in lieu of Stew, 12 oz. to the males, and 11 oz. to the females.

Extra.—Outdoor workers and Artizans, ½ pint Beer at 11 o'clock, a.m., and at 4 o'clock p.m.; 1 pint Tea at 5 p.m. Laundry women, ½ pint Beer, with bread and Cheese, at 11 a.m. Kitchen and Bakehouse women, 1 pint Beer extra daily. In Female Workroom, ½ pint Beer each, at 11 o'clock a.m. Tobacco and Snuff to be given as indulgences to the workers, etc.

The following Diet Scales are of interest ; enabling the reader to trace the changes which have taken place in this important element of treatment :—

HANWELL ASYLUM AT OPENING, 1831.

(*From the Treatise by Sir W. Ellis*, 1838.)

BREAD.—14 oz. daily for each patient.

BREAKFAST.

1½ pint of Rice, or Oatmeal Gruel, as is deemed most conductive to health. This is made in the following manner:—2 gallons of Milk, 2 gallons of Water, 2¾ pounds of Oatmeal or Rice, and a ¼ pound of Wheat-Flour are boiled together one hour.

DINNER.

Sunday.—Roast Beef; 6 oz. Uncooked Meat, free from bone; 4 oz. Yeast Dumpling, with the addition of 6 oz. Vegetables. Sometimes Potatoes are substituted for the Dumplings.

Tuesday.—Same as on Sunday, except that Boiled Mutton is substituted for the Beef.

Thursday.—Boiled Pork instead of Beef.

Saturday.—14 oz. Pie, made of the coarse Beef, with Potatoes.

Soup, made from the Meat boiled the day before, with the bones stewed, thickened with Barley, Rice, Peas, and Vegetables, and flavoured with Onions, Pot Herbs, and Cayenne Pepper, forms their Dinners on the other days of the week.

SUPPER.

Same as Breakfast.

As the season affords, the patients are sometimes indulged with Fruit Pies, and every Christmas they participate in the usual festivity of Roast Beef and Plum Pudding.

BEER.—One half-pint is the daily allowance at Dinner for the industrious and infirm. The healthy, who do not work, are not allowed malt liquor. Those who labour out of doors, or are really efficient in the wards, also receive one-third of a pint of Beer at eleven in the morning, and the same quantity at four in the afternoon.

Many of the patients, who are engaged in the domestic offices, receive indulgences ; and several, who assist the servants, sit up and partake with them of Supper. Various extras for the Sick are also allowed : but their rations are not stopped, and as they are frequently unable to participate in them, it necessarily increases the allowance for the actual consumers. In fact, this is sufficient, but I do not think superfluous.

SURREY ASYLUM AT OPENING, 1841.

(*From the Report of* 1843.)

DAYS.	BREAKFAST.	DINNER.	SUPPER.
Monday	1 pint of Milk Porridge, with 6 oz. of Bread.	Soup, *ad libitum*, thickened with Barley, Peas, and Vegetables, with 6 oz. of Bread.	1 pint of Milk Porridge, with 6 oz. of Bread.
Tuesday	Ditto	Boiled Mutton, in the proportion of 6 oz., free from bone, for each patient, with 4 oz. of Bread, ¾ of a pint of Beer, and Vegetables.	Ditto
Wednesday	Ditto	Suet Pudding, in the proportion of 16 oz. for male and 12 oz. for female patients, with Beer as before.	Ditto
Thursday ...	Ditto	Boiled or Roast Beef, etc., etc., in the same quantities to each as on Tuesday.	Ditto
Friday	Ditto	Baked Rice Pudding.	Ditto
Saturday.....	Ditto	Boiled Mutton, etc., etc., as on Tuesday.	Ditto
Sunday	Ditto	Boiled or Roast Beef, etc., etc., as on Thursday.	Ditto

The female patients employed in the Kitchen and Laundry are allowed for Luncheon, Bread and Cheese, and half a pint of Beer daily; and the whole of the female patients in employment, whether in the Kitchen, Laundry, or Wards, are each allowed weekly two ounces of Tea, eight ounces of Sugar, and eight ounces of Butter. The sick throughout the establishment are dieted at the discretion of the Medical Officers.

December 24th, 1842.

BETHLEM ROYAL HOSPITAL, 1837.

(*From Report appended to Narrative*, 1838.)

THE PATIENTS' DIET TABLE.

SUNDAY ..... Breakfast.—Gruel.
Dinner.—8 oz. Cooked Meat, 8 oz. Bread, Vegetables.
Supper.—8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.

MONDAY ..... Breakfast.—Gruel.
Dinner.—Baked Batter Puddings, 4 oz. Bread, 1 oz. Cheese, or ½ oz. Butter.
Supper.—8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.

TUESDAY ..... Breakfast.—Gruel.
Dinner.—8 oz. Cooked Meat, 8 oz. Bread, Vegetables.
Supper.—8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.

WEDNESDAY.. Breakfast.—Gruel.
Dinner.—Pea Soup, with Legs and Shins of Beef, 8 oz. Bread.
In the Summer Months, Baked Rice Puddings, 4 oz. Bread, 1 oz. Cheese, or ½ oz. Butter.
Supper.—8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.

THURSDAY ... Breakfast.—Gruel.
Dinner.—Boiled Suet Puddings, 4 oz. Bread, 1 oz. Cheese, or ½ oz. Butter.
Supper.—8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.

FRIDAY ..... Breakfast.—Gruel.
Dinner.—8 oz. Cooked Meat, 8 oz. Bread, Vegetables.
Supper.—8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.

SATURDAY ... Breakfast.—Gruel.
Dinner.—Rice Milk, 8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.
Supper.—8 oz. Bread, 2 oz. Cheese, or 1 oz. Butter.

Table Beer at Dinner and Supper daily.

EXTRAS FOR THE SICK.—Mutton Broth, Beef Tea, Puddings, Fish, Meat, Eggs, Wine, Strong Beer, Milk, etc., etc., or whatever may be ordered by the Medical Officers.

CHRISTMAS DAY.—8 oz. Roast Beef, 8 oz. Bread. (*Mem.*—If it fall on an ordinary Meat Day, the patients have a Meat Dinner on the following day.) A Mince Pie, 6d.

NEW YEAR'S DAY.—Plum Puddings in addition to the ordinary Dinner.

GOOD FRIDAY.—A Bun, 1d.

EASTER MONDAY.—8 oz. Roast Veal, 8 oz. Bread, Vegetables.

WHIT MONDAY.—8 oz. Roast Veal, 8 oz. Bread, Vegetables.

During the Summer, about the month of August, 6 oz. Boiled Bacon, Beans, 8 oz. Bread, 1 oz. Butter. Fruit, consisting of Currants and Gooseberries.

In the month of October, Apple Pies in addition to the ordinary Dinner.

BETHLEM ROYAL HOSPITAL, 1855.

(*From Dr. Hood's Decennial Report*, 1856.)

Every Day.. Males .. Tea, with 7 oz. Bread and Butter.
Females ,, 6 ditto.

Dinner.

Sunday.....	Males....	6 oz. Boiled Beef free from bone	4 oz. Bread,	¾	lb. Vegetables,	1	pt. Beer.
	Females...	5 ,,	4 ,,	½	,,	½	,,
Monday.....	Males.. ...	6 ,, Roast Mutton,	4 ,,	¾	,,	1	,,
	Females...	5 ,, ,,	4 ,,	½	,,	½	,,
Tuesday.....	Males.....	6 ,, Boiled Mutton,	4 ,,	¾	,,	1	,,
	Females...	5 ,, ,,	4 ,,	½	,,	½	,,
Wednesday	Males.....	6 ,, Roast Beef,	4 ,,	¾	,,	1	,,
	Females...	5 ,, ,,	4 ,,	½	,,	½	,,
Thursday.....	Same as Monday.						
Friday	Same as Tuesday.						
Saturday....	Males.....	16 oz. Meat Pie,	4 oz. Bread,	1	oz. Cheese,	1	pt. Beer.
	Females...	14 ,, ,,	4 ,,			½	,,

Supper.

Sunday, Monday, Tuesday, Thursday, and Friday } Males..... Same as Breakfast.
Wednesday and Saturday... Males..... 7 oz. Bread, 2 oz. Cheese, 1 pint Beer.
Every Day .....Females... Same as Breakfast.

Patients in employment in the Grounds, Workshops, or Laundry, to be allowed 4 oz. of Bread, 1 oz. Cheese, or ½ oz. of Butter, and ½ a pint of Beer for Luncheon, and ½ a pint of Beer in the afternoon.

Every patient to be allowed 1¾ oz. of Tea, 8 oz. of Sugar, 8 oz. of Butter, and 1½ pint Milk, weekly.

On Christmas Day, the Dinner to be Roast Beef and Plum Pudding.

On New Year's Day, a Mince Pie to be added to the usual fare.

On Good Friday, a Bun.

On Easter and Whit Monday, 6 oz. of Roast Veal to be allowed instead of the usual Meat for the day.

The Dinners to be further varied by the occasional substitution of Pork and Bacon, when Peas and Beans are in season; and also by the occasional substitution of Fish, and Fruit Pies, when Fish and Fruit are plentiful and good.

The Sick to be dieted at the discrction of the Resident Physician.

The Attendants to have at all times the means of obtaining Gruel for such patients as may require it.

The above to be considered maximum allowances, and all quantities unconsumed are to be taken in diminution of the next supply from the Stores of the Hospital.

ST. LUKE'S

(From the Physicians' OLD - -

MALES.

DAYS OF THE WEEK.	BREAKFAST.		DINNER.						SUPPER.		
	Milk and Water Gruel.	Bread.	Cooked Meat, with bone.	Potatoes.	Bread.	Cooked Rice, baked or boiled.	Cheese.	Beer.	Bread.	Cheese or Butter.	Beer.
	pints.	oz.	oz.	oz.	oz.	oz.	oz.	pints.	oz.	oz.	pints.
Sunday	2	2	12	12	6	...	...	1	8	2	1
Monday *	2	2	5*	...	6	...	...	...	8	2	1
Tuesday	2	2	12	12	6	...	...	1	8	2	1
Wednesday	2	2	12	12	6	...	...	1	8	2	1
Thursday	2	2	12	12	6	...	...	1	8	2	1
Friday*	2	2	5*	...	6	...	...	...	8	2	1
Saturday	2	2	...	...	6	16	2	1	8	2	1
Week's Allowance	14	14	58	48	42	16	2	5	56	14	7

* Being at the rate of two stone of Fresh Meat for every 50 patients; which, with the liquor of the preceding day's Meat, with Peas, etc., made an allowance of two pints of Broth for the men, and a pint and a half for the women on these days.

MALES.

NEW - -

DAYS OF THE WEEK.	BREAKFAST.					DINNER.						SUPPER.		
	Cocoa.	Milk.	Half oz. Sugar, or 1 oz. Treacle.	Bread.	Butter.	Cooked Meat, with bone.	Potatoes.	Bread.	Boiled Rice.	Flour.	Beer.	Bread.	Cheese.	Beer.
	oz.	pints.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	pints.	oz.	*o.	pints.
Sunday	½	½	1	8	½	8	12	6	...	...	1	8	2	1
Monday	½	½	1	8	½	8	12	6	...	...	1	8	2	1
Tuesday	½	½	1	8	½	8	...	3	...	4	1	8	2	1
Wednesday	½	½	1	8	½	8	...	3	8	...	1	8	2	1
Thursday	½	½	1	8	½	8	12	6	...	...	1	8	2	1
Friday	½	½	1	8	½	5*	...	6*	...	...	...	8	2	1
Saturday	½	½	1	8	½	8	12	6	...	...	1	8	2	1
Week's Allowance	3½	1½	7	56	3½	53	48	36	8	4	6	56	14	7

* With Peas and Vegetables for Soup.

Note.—The above to be considered *maximum* allowances, and all quantities unconsumed are to be taken in diminution of the next supply from the Stores of the Hospital. The Dinners to be further varied by the occasional substitution of Fish, and Fruit Pies, or Puddings, when Fish and Fruit are plentiful and good. The Sick to be dieted at the discretion of the Medical Officers.

HOSPITAL.

- - *Report for* 1854.)

DIETARY.

FEMALES.

BREAKFAST.		DINNER.						SUPPER.		
Milk and Water Gruel.	Bread.	Cooked Meat, with bone.	Potatoes.	Bread.	Cooked Rice, baked or boiled.	Cheese.	Beer.	Bread.	Cheese or Butter.	Beer.
pints.	oz.	oz.	oz.	oz.	oz.	oz.	pints.	oz.	oz.	pints.
1½	2	8	8	6	...	...	½	8	2	½
1½	2	5*	...	6	...	...	...	8	2	½
1½	2	8	8	6	...	...	½	8	2	½
1½	2	8	8	6	...	...	½	8	2	½
1½	2	8	8	6	...	...	½	8	2	½
1½	2	5*	...	6	...	...	...	8	2	½
1½	2	...	...	6	12	2	½	8	2	½
10½	14	42	32	42	12	2	3½	56	14	5½

Note.—The above was the Ordinary Diet without distinction as to pauper or private patients.—Those patients who were employed in various ways were allowed an extra quantity of food by way of Luncheon, and those who were sick were provided with any description of diet ordered by the Medical Officers.

DIETARY.

FEMALES.

BREAKFAST.					DINNER.						SUPPER.				
Cocoa.	Milk.	1 oz. Treacle, or half oz. Sugar.	Bread.	Butter.	Cooked Meat, with bone.	Potatoes.	Bread.	Boiled Rice.	Flour.	Beer.	Tea.	Milk.	Sugar.	Bread.	Butter.
oz.	pints.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	oz.	pints.	oz.	pints.	oz.	oz.	oz.
½	½	1	6	½	6	8	6	...	...	½	½	½	½	8	½
½	½	1	6	½	6	8	6	...	...	½	½	½	½	8	½
½	½	1	6	½	6	...	3	...	4	½	½	½	½	8	½
½	½	1	6	½	6	...	3	8	...	½	½	½	½	8	½
½	½	1	6	½	6	8	6	...	...	½	½	½	½	8	½
½	½	1	6	½	4*	...	6*	...	...	...	½	½	½	8	½
½	½	1	6	½	6	8	6	...	...	½	½	½	½	8	½
3½	1½	7	42	3½	40	32	36	8	4	4½	1	½	3½	56	3½

* With Peas and Vegetables for Soup.

The following is from an appendix to the report of a special committee of the Charity Organization Society, on the "Education and Care of Idiots, Imbeciles, and Harmless Lunatics," presented to the Council January 15, 1877:—

"ESTIMATE OF THE NUMBER OF IDIOTS, IMBECILES, AND HARMLESS LUNATICS, NEEDING PUBLIC AMINISTRATION; being two-thirds of the total number (this proportion being chargeable to the Poor-Rate), and one-fifth of the remaining third being added. Harmless lunatics are calculated at one-fourth of the total number of Lunatics included in the census of April 3, 1871. An addition of five per cent. for increase of population has been made in all the columns.

	Districts.	Population.	Idiots and Imbeciles under 20 years of age.	Adult Idiots and Imbeciles.	Harmless Lunatics.	Total of Adult Idiots and Harmless Lunatics.
1	London	3,416,973	811	1023	698	1721
2	South-Eastern	2,276,112	1580	2451	1079*	3530
3	South Midland	1,514,787	762	1403	1399*	2802
4	Eastern	1,279,664	727	1118	446	1564
5	South-Western	1,974,816	1014	1692	719	2411
6	West Midland	2,856,702	1478	2603	917	3520
7	North Midland.....	1,477,282	711	1324	317	1641
8	North-Western.....	3,558,496	1441	2475	819	3294
9	York	2,515,347	970	1590	544	2134
10	Northern	1,484,946	480	844	342	1186
11	Monmouthshire and Wales	1,492,754	625	1226	335	1561
		23,847,879	10,599	17,749	7615	25,364

Under 20 years of age	10,599
Above ,, ,, ...	25,364
Total	35,963

"The above numbers include 25 per cent. for idiots and imbeciles not returned in the Census, of whom 20 per cent. are apportioned to cases under 20 years of age, and the remaining five per cent. to Adult Idiots and Imbeciles."

"* The actual number of Harmless Lunatics in these two districts exceeds the proportion of one-fourth, owing to the London cases being placed at Caterham and Leavesden in those districts."

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